EBMT Centre Identification Code (CIC): _ _ _ _
Hospital Unique Patient Number (UPN): _ _ _ _ _ _ _ _ _ _ _ _
Patient Number in EBMT Registry: _ _ _ _ _ _ _ _ _

Treatment Type ☐ IST

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

IMMUNOSUPPRESSIVE TREATMENT (IST)
Day 0 *(For Bone Marrow Failure only)*

This form should be filled in for each individual immunosuppressive treatment episode.

Date this IST episode started: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Centre where this IST took place (CIC): _ _ _ _

Patient UPN for this treatment: _____

Team or unit where treatment took place *(select all that apply):*

☐ Adults ☐ Pediatrics ☐ Hematology ☐ Oncology ☐ Allograft ☐ Autograft ☐ Other; specify: _____

Unit number: _____ ☐ Not applicable

Indication diagnosis for this IST episode:_____
(make sure you registered indication diagnosis using relevant diagnosis form first)

Chronological number of this treatment: _____
(*all types of treatments for this patient, e.g. HCT, CT, GT, IST*)

Reason for this IST episode:

☐ First line treatment
☐ Failure of first line therapy
☐ Relapse
☐ PR to previous treatment
☐ Other; specify: _____
☐ Unknown

Chronological number of this IST episode: _____

TRANSFUSIONS

Complete this section only if this is the first IST episode ever for this patient:

RBC transfusions given before the 1st IST episode: ☐ **No** ☐ **Yes** ☐ **Unknown**

RBC: ☐ < 20 units ☐ 20 - 50 units ☐ > 50 units ☐ Unknown

RBC irradiated: ☐ No ☐ Yes ☐ Unknown

Platelet transfusions given before the 1st IST episode: ☐ **No** ☐ **Yes** ☐ **Unknown**

Platelets: ☐ < 20 units ☐ 20 - 50 units ☐ > 50 units ☐ Unknown

Platelets irradiated: ☐ No ☐ Yes ☐ Unknown

EBMT Centre Identification Code (CIC): _ _ _ _
Hospital Unique Patient Number (UPN): _ _ _ _ _ _ _ _ _ _ _
Patient Number in EBMT Registry: _ _ _ _ _ _ _ _ _

Treatment Type ☐ IST

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

IMMUNOSUPPRESSION

Drugs used for immunosuppression during this IST episode (check at least one)**:**

Drug given	**Start Date** *(YYYY/MM/DD)*	**Stop Date (***YYYY/MM/DD)*	
☐ Alemtuzumab	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Anti-CD20 antibodies	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Anti-Thymocyte Globulin (ATG) Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Beclometasone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Budesonide (for systemic immunosuppression)	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Cyclophosphamide	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Cyclosporine	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Danazol	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Dexamethasone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Etiocholanolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Filgrastim	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Fluoxymesterone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Lenograstim	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Methylprednisolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Mycophenolate mofetil	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Nandrolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Norethandrolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Oxandrolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Oxymetholone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Pegfilgrastim	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Prednisolone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Testosterone	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown
☐ Other; specify*: _____	_ _ _ _/ _ _/ _ _	_ _ _ _/ _ _/ _ _	☐ Unknown

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names

proceed to form DISEASE STATUS AT HCT/CT/GT/IST