

ALLOGENEIC HAEMATOPOIETIC CELL TRANSPLANTATION (HCT) Day 0

Date of this HCT: ____/____/____ (YYYY/MM/DD)
(or planned date of HCT if patient died before treatment)

Centre where this HCT took place: _____

Patient UPN for this treatment: _____

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

Adults Pediatrics Haematology Oncology Allograft Autograft Other; specify: _____

Unit number: _____ Not applicable

Indication diagnosis for this HCT: _____
(make sure the indication diagnosis has been registered first, using the relevant diagnosis form)

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

Chronological number of this HCT: _____
(Include all HCTs this patient received in the past)

Chronological number of this allogeneic HCT: _____
(Include all allogeneic HCTs this patient received in the past)

ALLOGENEIC HAEMATOPOIETIC CELL TRANSPLANTATION (HCT) Day 0

Complete this section only if the chronological number of the treatment is >1 for this patient.

If > 1:

Reason for this HCT:

- Indication diagnosis
- Relapse/progression after previous treatment (HCT/CT/GT/IST)
- Complication after previous treatment (HCT/CT/GT/IST)
- Primary graft failure
- Secondary graft failure
- Secondary malignancy
- Other; specify: _____

Date of the last main treatment before this one: ____/____/____ (YYYY/MM/DD)

A main treatment refers to HCT, cellular therapy, gene therapy and immunosuppressive treatment

Type of the last main treatment before this one:

- Autologous HCT
- Allogeneic HCT
- Cellular therapy (CT)
- Immunosuppressive treatment (IST)
- Gene therapy (GT)

Was the last main treatment performed at another institution?

- No
- Yes: CIC (if known): _____

Name of institution: _____

City: _____

Submit the relevant follow-up form for the previous HCT/CT/GT/IST using the follow up assessment date before this HCT. It is required to capture relapse data and other events between transplants/cellular therapies.



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

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

DONOR & GRAFT

Is this HCT part of a (planned) multiple (sequential) graft program/protocol?

- No
- Yes: **Chronological number of this HCT as part of multiple (sequential) graft program/protocol for this patient:** _____

If this is the first allogeneic HCT for this patient, complete the patient HLA section in the database.

Multiple donors (including multiple CB units):

- No
- Yes: **Number of donors:** _____

DONOR INFORMATION

--- Donor __ (number)---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

Did the donor consent to having their data in the EBMT registry?

- No (complete only fields marked with '*' on pages 4-8)
 Yes

Date of birth: ____/____/____ (YYYY/MM/DD)

(year of birth is a mandatory field)

(Skip if the source of stem cells is cord blood)

***Age at time of donation:** _____ years
(optional)

***Age in months:** _____
(optional, if the donor was younger than 2 years)

***Sex (at birth):**

- Male
 Female

Donor Identification:

Donor ID given by the treating centre *(mandatory)*: _____

Global registration identifier for donors (GRID): _____

ION code of the Donor Registry or Cord Blood Bank *(mandatory)*: _____

EuroCord code for the Cord Blood Bank *(if applicable)*: _____

Name of Donor Registry or Cord Blood Bank: _____

Donor ID given by the Donor Registry or Cord Blood Bank: _____

Patient ID given by the Donor Registry or Cord Blood Bank: _____

***Donor blood group:**

- A
 B
 AB
 O

***Donor rhesus factor:**

- Negative
 Positive

***Donor EBV status:**

- Negative
 Positive
 Not evaluated
 Unknown

***Donor CMV status:**

- Negative
 Positive
 Not evaluated
 Unknown

Is donor heterozygous? *(Sickle cell disease only)

- No
 Yes

Is donor a carrier for X-linked disease? *(Inborn Errors only)

- No
 Yes

***Did this donor provide more than one stem cell product:**

- No
 Yes: ***Number of different stem cell products from this donor:** _____

(If 2 products e.g. BM and PM, complete 'Donor 1 - Product Number 1 and 2' on page 5)

DONOR INFORMATION

--- Donor __ (number) continued ---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

*Donor __ (number) - Product Number 1

If more than one stem cell product, this is the first product collected from this donor.

***Source of stem cells:** Bone Marrow Peripheral Blood Cord Blood Other; specify: _____
(select only one)

***Graft manipulation ex-vivo including T-cell depletion:**
(other than for RBC removal or volume reduction)

No

*Yes: T-cell (CD3+) depletion (*Do not use for "Campath in the bag"*)

T-cell receptor $\alpha\beta$ depletion

B-cell depletion (CD19+) by MoAB

NK cell depletion by MoAB

CD34+ enrichment: UM171 (Zemcelpro; dorocubicel and unexpanded CD34- cells)

Nicotinamide (NAM) (Omisirge; omidubicel-only)

Notch ligand-based expansion

Genetic manipulation

Other; specify: _____

***Was the graft cryopreserved prior to infusion?**

No

Yes; *Date of cryopreservation: ____/____/____ (YYYY/MM/DD) Unknown

Unknown

DONOR INFORMATION
--- Donor __ (number) continued ---
Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

***Donor __ (number) - Product Number 2**

If more than one stem cell product, this is the first product collected from this donor.

***Source of stem cells:** Bone Marrow Peripheral Blood Cord Blood Other; specify: _____
(select only one)

***Graft manipulation ex-vivo including T-cell depletion:**
(other than for RBC removal or volume reduction)

No

*Yes: T-cell (CD3+) depletion (*Do not use for "Campath in the bag"*)

- T-cell receptor αβ depletion
- B-cell depletion (CD19+) by MoAB
- NK cell depletion by MoAB
- CD34+ enrichment: UM171 (Zemcelpro; dorocubicel and unexpanded CD34- cells)
- Nicotinamide (NAM) (Omisirge; omidubicel-only)
- Notch ligand-based expansion
- Genetic manipulation
- Other; specify: _____

***Was the graft cryopreserved prior to infusion?**

- No
- Yes; ***Date of cryopreservation:** ____/____/____ (YYYY/MM/DD) Unknown
- Unknown

DONOR INFORMATION
--- Donor __ (number) continued ---
Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

***Relation between patient and donor:** Related:

Relationship to patient: Syngeneic (monozygotic twin)
 Sibling (may include non-monozygotic twin)
 Other related: Parents
 Child
 Aunt/Uncle
 Cousin
 Grand Parents
 Other; specify: _____

Unrelated (proceed to next page)

Related donor:

***Both haplotypes confirmed by family studies?** No
 (for both matched and mismatched related donors) Yes
 Unknown

***HLA match type:** *Match (both haplotypes matched)

*Mismatch: ***Method used for patient/donor HLA typing:** Molecular
 (select all that apply) Serology

if molecular typing was done:

*Locus:	*Number of mismatches, allelic:
A:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated

if serological typing was done:

*Locus:	*Number of mismatches, antigenic:
A:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated

***Please enter the LABORATORY RESULTS WITH HLA TYPING into the database for all the donors**

DONOR INFORMATION
--- Donor __ (number) continued ---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

Unrelated donor:

***HLA match type:**

***Method used for patient/donor HLA typing:** Molecular
 (select all that apply) Serology

if molecular typing was done:

*Locus:	*Number of mismatches, allelic:
A:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated

if serological typing was done:

*Locus:	*Number of mismatches, antigenic:
A:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Not evaluated

****Please enter the LABORATORY RESULTS WITH HLA TYPING into the database for all the donors***

ADDITIONAL ASSESSMENTS
(All diagnoses)

Are there Donor-Specific Antibodies (DSA) against HLA?

<input type="checkbox"/> No							
<input type="checkbox"/> Yes: HLA loci the DSA are directed against: <table style="display: inline-table; vertical-align: middle; margin-left: 20px;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> DRB1</td> </tr> <tr> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> DQB1</td> </tr> <tr> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> DPB1</td> </tr> </table>		<input type="checkbox"/> A	<input type="checkbox"/> DRB1	<input type="checkbox"/> B	<input type="checkbox"/> DQB1	<input type="checkbox"/> C	<input type="checkbox"/> DPB1
<input type="checkbox"/> A	<input type="checkbox"/> DRB1						
<input type="checkbox"/> B	<input type="checkbox"/> DQB1						
<input type="checkbox"/> C	<input type="checkbox"/> DPB1						
<p>Did the patient have desensibilisation therapy? <input type="checkbox"/> No <i>(Haemoglobinopathies only)</i> <input type="checkbox"/> Yes; specify: _____</p>							
<p>Are the DSA red cell antibodies? <input type="checkbox"/> No <i>(Haemoglobinopathies only)</i> <input type="checkbox"/> Yes: Are they cross-reacting with the red cells of the donor? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>							
<input type="checkbox"/> Not evaluated							
<input type="checkbox"/> Unknown							

PREPARATIVE REGIMEN
(All Diagnoses)

Preparative (conditioning) regimen given?

- No
 Yes

Drugs given? *(any active agent, including chemotherapy, monoclonal antibody, polyclonal antibody, serotherapy, etc.)*

- No
 Yes (provide details in the table on pages 10-11)

What type of conditioning regimen was used?

- Reduced intensity conditioning (RIC)
 Myeloablative conditioning (MAC)

PREPARATIVE REGIMEN continued

Specification and dose of the preparative regimen:

(Report the total prescribed cumulative dose as per protocol. Multiply daily dose by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg. Report dosages and units only for individual drugs.)

Chemotherapy	Dose	Unit
<input type="checkbox"/> Bendamustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Bleomycin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Busulfan Route of administration: <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Both Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carboplatin Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carmustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cisplatin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Clofarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
Corticosteroids:		
<input type="checkbox"/> Beclometasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Budesonide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Dexamethasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Methylprednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Prednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cyclophosphamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cytarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Daunorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Doxorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Epirubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Etoposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Fludarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Gemtuzumab ozogamicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Ibritumomab tiuxetan	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Idarubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg

PREPARATIVE REGIMEN continued

Specification and dose of the preparative regimen:

(Report the total prescribed cumulative dose as per protocol. Multiply daily dose by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg.)

Chemotherapy	Dose	Units
<input type="checkbox"/> Ifosfamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Imatinib	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Lomustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Melphalan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Mitoxantrone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Paclitaxel	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-CD20 antibodies	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Teniposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Thiotepa	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Tositumomab	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Treosulfan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Other; specify*: _____	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg <input type="checkbox"/> mCi <input type="checkbox"/> MBq

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

Total body irradiation (TBI):

- No
- Yes; **Total prescribed radiation dose as per protocol (Gy):** _____
- Number of fractions:** _____
- Number of radiation days:** _____

Total lymphatic irradiation (TLI):

- No
- Yes; **Total prescribed radiation dose as per protocol (Gy):** _____
- Number of fractions:** _____
- Number of radiation days:** _____

Total abdominal irradiation (TAI):

- No
- Yes; **Total prescribed radiation dose as per protocol (Gy):** _____
- Number of fractions:** _____
- Number of radiation days:** _____

