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

Treatment Type ☐ HCT

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

AUTOLOGOUS 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 (CIC): _____

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 HCT/CT/GT/IST event: _____
(It is an order/rank number for this type of treatment event, not the patient's full treatment history. Please Indicate whether this is the 1st, 2nd, 3rd, etc. HCT/CT/GT/IST event recorded for this patient. IST is applicable only for BMF, please don't count IST treatment for other diseases.)

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

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

AUTOLOGOUS 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 imunosuppressive 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.

GRAFT INFORMATION

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:** _____

Source of stem cells:
(check all that apply)

☐ Bone marrow

☐ Peripheral blood

☐ Cord blood

☐ Other; specify: _____

Graft manipulation *ex-vivo*:
(other than for gene therapy, RBC removal or volume reduction)

☐ No

☐ Yes: ☐ CD34+ enrichment

☐ Other manipulation; specify: _____

Was the graft cryopreserved prior to infusion?

☐ No

☐ Yes

☐ Unknown

MOBILISATION
Autoimmune Diseases only

Mobilisation drugs given?

☐ No

☐ Yes; Start date of mobilisation: _ _ _ _ / _ _ / _ _ (*YYYY/MM/DD)*

Cyclophosphamide:	☐ No	☐ Yes	Dose (g/m²): _____
Corticosteroids:	☐ No	☐ Yes	Daily dose (mg/kg): _____
G-CSF:	☐ No	☐ Yes	
Plerixafor:	☐ No	☐ Yes	

Other; specify*: _____

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

PREPARATIVE REGIMEN
(All Diagnoses)

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

☐ No *(usually paediatric inherited disorders only)*

☐ Yes (provide details on pages 5-6)

Autoimmune diseases only:

Serotherapy given (ATG, ALG, alemtuzumab)?

☐ No

☐ Yes :
- ☐ **Alemtuzumab**
- ☐ **Rituximab**
- ☐ **ATG**
- ☐ **Other serotherapy; specify:** _____

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	Unit
☐ Alemtuzumab	_____	☐ mg/m² ☐ mg/kg
☐ Anti-Thymocyte Globulin|Anti-Lymphocyte Globulin Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____	_____	☐ mg/m² ☐ mg/kg
☐ Bendamustine	_____	☐ mg/m² ☐ mg/kg
☐ Bleomycin	_____	☐ mg/m² ☐ mg/kg
☐ Busulfan Route of administration: ☐ Oral ☐ IV ☐ Both Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carboplatin Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carmustine	_____	☐ mg/m² ☐ mg/kg
☐ Cisplatin	_____	☐ mg/m² ☐ mg/kg
☐ Clofarabine	_____	☐ mg/m² ☐ mg/kg
Corticosteroids:		
☐ Beclometasone	_____	☐ mg/m² ☐ mg/kg
☐ Budesonide	_____	☐ mg/m² ☐ mg/kg
☐ Dexamethasone	_____	☐ mg/m² ☐ mg/kg
☐ Methylprednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Prednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Cyclophosphamide	_____	☐ mg/m² ☐ 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.
Report dosages and units only for individual drugs.)

Chemotherapy	Dose	Units
☐ Cytarabine	_____	☐ mg/m^2 ☐ mg/kg
☐ Daunorubicin	_____	☐ mg/m^2 ☐ mg/kg
☐ Doxorubicin	_____	☐ mg/m^2 ☐ mg/kg
☐ Epirubicin	_____	☐ mg/m^2 ☐ mg/kg
☐ Etoposide	_____	☐ mg/m^2 ☐ mg/kg
☐ Fludarabine	_____	☐ mg/m^2 ☐ mg/kg
☐ Gemtuzumab ozogamicin	_____	☐ mg/m^2 ☐ mg/kg
☐ Ibritumomab tiuxetan	_____	☐ mCi ☐ MBq
☐ Idarubicin	_____	☐ mg/m^2 ☐ mg/kg
☐ Ifosfamide	_____	☐ mg/m^2 ☐ mg/kg
☐ Imatinib	_____	☐ mg/m^2 ☐ mg/kg
☐ Lomustine	_____	☐ mg/m^2 ☐ mg/kg
☐ Melphalan	_____	☐ mg/m^2 ☐ mg/kg
☐ Mitoxantrone	_____	☐ mg/m^2 ☐ mg/kg
☐ Paclitaxel	_____	☐ mg/m^2 ☐ mg/kg
☐ Anti-CD20 antibodies	_____	☐ mg/m^2 ☐ mg/kg
☐ Teniposide	_____	☐ mg/m^2 ☐ mg/kg
☐ Thiotepa	_____	☐ mg/m^2 ☐ mg/kg
☐ Tositumomab	_____	☐ mCi ☐ MBq
☐ Treosulfan	_____	☐ mg/m^2 ☐ mg/kg
☐ Other; specify*: _____	_____	☐ mg/m^2 ☐ mg/kg ☐ mCi ☐ 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: _____

END OF THE AUTO-HCT DAY 0 REPORT

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