CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

DAY 0	MED-B GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) ....

Hospital ..... Unit .....

Contact person: .....

e-mail .....

Date of this report .... - .... - ....
yyyy mm dd

STUDY/TRIAL

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

PATIENT

Unique Identification Code (UIC) .... *(to be entered only if patient previously reported)*

Hospital Unique Patient Number or Code (UPN): .....
Compulsory, registrations will not be accepted without this item.
All transplants performed in the same patient must be registered with the same patient identification number or code as this belongs to the patient and not to the transplant.

Initials .... (first name(s) – surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

ABO Group ....

Rh factor: ☐ Absent ☐ Present ☐ Not evaluated

DISEASE

Date of diagnosis : .... - .... - ....
yyyy mm dd

PRIMARY DISEASE DIAGNOSIS *(CHECK THE DISEASE FOR WHICH THIS TRANSPLANT WAS PERFORMED)*

- ☐ Primary Acute Leukaemia
  - ☐ Acute Myelogenous Leukaemia (AML) & related Precursor Neoplasms
  - ☐ Precursor Lymphoid Neoplasms (old ALL)
- ☐ Therapy related myeloid neoplasms (old Secondary Acute Leukaemia)
- ☐ Chronic Leukaemia
  - ☐ Chronic Myeloid Leukaemia (CML)
  - ☐ Chronic Lymphocytic Leukaemia (CLL)
- ☐ Lymphoma
  - ☐ Non Hodgkin
  - ☐ Hodgkin's Disease
- ☐ Myeloma /Plasma cell disorder
- ☐ Solid Tumour
- ☐ Myelodysplastic syndromes / Myeloproliferative neoplasm
  - ☐ MDS
  - ☐ MDS/MPN
  - ☐ Myeloproliferative neoplasm
- ☐ Bone marrow failure including Aplastic anaemia
- ☐ Inherited disorders
  - ☐ Primary immune deficiencies
  - ☐ Metabolic disorders
- ☐ Histiocytic disorders
- ☐ Autoimmune disease
  - ☐ Juvenile Idiopathic Arthritis (JIA)
  - ☐ Multiple Sclerosis
  - ☐ Systemic Lupus
  - ☐ Systemic Sclerosis
- ☐ Haemoglobinopathy

☐ Other diagnosis, specify:_____

DAY 0

MED-B
CHRONIC MYELOID LEUKAEMIA

INITIAL DIAGNOSIS

Has the information requested in this section been submitted with a previous HSCT registration?
☐ Yes: go to page 3 ☐ No: proceed with this section

Subclassification *(CMML is not a CML but an MDS/MPN overlap syndrome)*
At least one investigation must be positive

Translocation (9;22)	☐ Absent	☐ Present	☐ Not evaluated
bcr-abl	☐ Absent	☐ Present	☐ Not evaluated

STATUS OF DISEASE AT DIAGNOSIS

☐ Chronic phase ☐ Blast crisis ☐ Accelerated phase

CYTOGENETICS OTHER THAN FOR TRANSLOCATION (9;22) AT DIAGNOSIS

☐ Normal: number of metaphases examined: .....

☐ Abnormal: number of metaphases with abnormalities: ..... / number of metaphases examined: .....

Abnormalities *Indicate type of abnormality and write chromosomes involved*

☐ Translocation ..... ☐ Deletion ..... ☐ Inversion .....
☐ Isochromosome..... ☐ Multiple (=>3) ..... ☐ Hypodiploid .....
☐ Hyperdiploid ..... ☐ Monosomy ..... ☐ Trisomy .....
☐ Other .....

☐ Not done or failed

☐ Unknown

HAEMATOLOGICAL VALUES AT DIAGNOSIS

Peripheral blood

Hb (g/dL)	....	☐ Not evaluated
Platelets (10^9/L)	....	☐ Not evaluated
White Blood Count (10^9/L)	....	☐ Not evaluated
% basophils	....	☐ Not evaluated
% blasts	....	☐ Not evaluated

Bone marrow

% blasts	....	☐ Not evaluated

Palpable splenomegaly ☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

Physical examination *(if present)*: ..... cm (below costal margin) ☐ Not evaluated

Spleen span in ultrasound or CT scan: ..... cm (maximum diameter) ☐ Not evaluated

TREATMENT PRE-HSCT

TREATMENT PRE-HSCT (PRIMARY TREATMENT)

☐ No
Proceed to Date of HSCT

☐ Yes:

Date Treatment started .... - .... - ....
yyyy mm dd

Chemotherapy/Drugs ☐ No ☐ Yes ☐ Unknown

If yes:

Tyrosine Kinase Inhibitor (TKI) given:	**Date started**	**Date ended** *If treatment is still being given on date of HSCT, enter date of HSCT and tick **Ongoing***	**Ongoing**
☐ No			
☐ Yes:			
☐ Imatinib	From: .... - .... -	to: .... - .... -	☐
☐ Nilotinib	From: .... - .... -	to: .... - .... -	☐
☐ Dasatinib	From: .... - .... -	to: .... - .... -	☐
☐ Bosutinib	From: .... - .... -	to :..... ..... - .... -	☐
☐ Ponatinib	From: .... - .... -	to: .... - .... -	☐
☐ Other, specify	From: .... - .... -	to: .... - .... -	☐

Other chemotherapies:

☐ Interferon α	From: .... - .... -	to: .... - .... -	☐
☐ Hydroxyurea	From: .... - .... -	to: .... - .... -	☐
☐ Busulfan	From: .... - .... -	to: .... - .... -	☐
☐ Cytosine arabinoside *(ARAC)*	From: .... - .... -	to :..... ..... - .... -	☐
☐ Other, specify	From: .... - .... - .... *yyyy mm dd*	to: .... - .... - .... *yyyy mm dd*	☐

Other treatment ☐ No ☐ Yes, specify: .... ☐ Unknown

HSCT DATE and TYPE

DATE OF HSCT : .... - .... - ....
yyyy mm dd

Splenectomy ☐ Yes, date:..... ..... - .... - .... ☐ No
yyyy mm dd

HSCT TYPE ☐ Allogeneic
☐ Autologous

REASON FOR THE HSCT *(tick one main reason only and as many secondary as applicable)*

	MAIN	SECONDARY
Advanced phase	☐	☐
Imatinib resistance	☐	☐
Dasatinib resistance	☐	☐
Nilotinib resistance	☐	☐
Clonal evolution	☐	☐
Poor risk patient or high risk CML (e.g. Sokal > 1.2)	☐	☐
ABL mutation	☐	☐
Standard indication at diagnosis	☐	☐
No engraftment after allo BMT	☐	☐
Clinical study	☐	☐
Other, specify :	☐	☐

STATUS OF DISEASE AT MOBILISATION *ONLY IF AUTOGRAFT*

FOR AUTOGRAFT ONLY. If allograft, proceed to "Status at HSCT" on page 5

DATE OF COLLECTION: .... - .... - ....
yyyy mm dd

PHASE	NUMBER	TYPE OF REMISSION *Check all that apply*		
		HAEMATOLOGICAL	CYTOGENETIC	MOLECULAR
☐ Chronic phase (CP)	☐ 1st ☐ 2nd ☐ 3rd or higher	☐ Yes ☐ No ☐ Not evaluated ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not applicable* ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not applicable* ☐ Unknown

* *No abnormalities detected prior to this time point*

CYTOGENETICS OF MOBILISED PRODUCT
(To be completed only if disease status is not cytogenetic remission)

Translocation (9;22)

☐ Absent
☐ Present: % Translocation (9;22) metaphases: .....

If evaluated: Number of metaphases examined: .....

☐ Not evaluated
☐ Unknown

FISH analysis t (9;22) done

☐ Negative
☐ Positive: % of positive cells: .....

If done: Number of cells examined .....

☐ Not evaluated
☐ Unknown

Additional cytogenetic analysis? ☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

MOLECULAR STATUS OF MOBILISED PRODUCT

TO BE COMPLETED ONLY IF DISEASE STATUS IS NOT MOLECULAR REMISSION

Molecular marker BCR-ABL ☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

STATUS OF DISEASE AT HSCT

PHASE	NUMBER	TYPE OF REMISSION *check all that apply*		
		HAEMATOLOGICAL	CYTOGENETIC	MOLECULAR
☐ Chronic phase (CP)	☐ 1st ☐ 2nd ☐ 3rd or higher	☐ Yes ☐ No ☐ Not evaluated ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not applicable* ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not applicable* ☐ Unknown
☐ Accelerated phase	☐ 1st ☐ 2nd ☐ 3rd or higher			
☐ Blast crisis	☐ 1st ☐ 2nd ☐ 3rd or higher	TYPE OF BLAST CRISIS ☐ Myeloid ☐ Lymphoid ☐ Other (erythroblastic or megakaryoblastic or mixed)		

* *No abnormalities detected prior to this time point*

CYTOGENETICS AT HSCT

Translocation (9;22) *(To be completed only if disease status is not cytogenetic remission)*

☐ Absent

☐ Present: % Translocation (9;22) metaphases: .....

If evaluated: Number of metaphases examined: .....

☐ Not evaluated

☐ Unknown

FISH analysis t (9;22) done

☐ Negative

☐ Positive: % of positive cells: .....

If done: Number of cells examined .....

☐ Not evaluated

☐ Unknown

Additional cytogenetic analysis? ☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

MOLECULAR STATUS AT HSCT

TO BE COMPLETED ONLY IF DISEASE STATUS IS NOT MOLECULAR REMISSION

Molecular marker BCR-ABL ☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

IF BCR-ABL PRESENT AND DISEASE STATUS IS NOT CYTOGENETIC REMISSION FILL IN THE RESULTS:

BCR-ABL result *(number of copies/μg of RNA)*: …… ☐ Not evaluated

Control gene result *(number of copies/μg of RNA)*: …… ☐ Not evaluated

Bcr-abl/control gene ratio: …… %

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

HAEMATOLOGICAL VALUES AT HSCT

Peripheral blood

Hb (g/dL) .... ☐ Not evaluated
Platelets (10^9/L) .... ☐ Not evaluated
White Blood Count (10^9/L) .... ☐ Not evaluated
% basophils .... ☐ Not evaluated
% blasts .... ☐ Not evaluated

Bone marrow

% blasts .... ☐ Not evaluated

Large foci or clusters of blasts in BM ☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

Extramedullary blast proliferation ☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

Palpable splenomegaly ☐ Absent ☐ Present ☐ Not evaluated ☐ Not applicable
(splenectomy performed in the past)

Physical examination *(if present)*: ..... cm (below costal margin) ☐ Not evaluated
Spleen span in ultrasound or CT scan: ..... cm (maximum diameter) ☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF HSCT

☐ AUTOgraft, **proceed to Autograft day 0 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 0 form**

If ☐ Other : ..... , contact the EBMT Central Registry Office for instructions

DAY 100	MED-B CHRONIC MYELOID LEUKAEMIA

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Date of this report .... - .... - ....
yyyy mm dd

Hospital Unique Patient Number ..... .

Initials: ....._..... (first name(s)_surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of the most recent transplant before this follow up: ..... - ..... - .....
yyyy mm dd

DISEASE STATUS AT DAY +100 POST HSCT

Molecular remission	☐ Yes	☐ No	☐ Not evaluated
Cytogenetic remission	☐ Yes	☐ No	☐ Not evaluated
Haematological remission	☐ Yes	☐ No	☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

☐ AUTOgraft, **proceed to Autograft day 100 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 100 form**

FOLLOW UP	MED-B CHRONIC MYELOID LEUKAEMIA

Please use this form for annual follow up only and not data at 100 days, which is already included in the first report

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Date of this report .... - .... - ....
yyyy mm dd

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

Hospital Unique Patient Number ..... .

Initials: ....._..... (first name(s)_surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of the most recent transplant before this follow up: ..... - ..... - .....
yyyy mm dd

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH: .... - .... - ....
yyyy mm dd

Complications after Transplant (Allografts)

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

Maximum grade ☐ grade 0 *(Absent)* ☐ grade I ☐ grade II ☐ grade III ☐ grade IV ☐ Not evaluated

If present: ☐ New onset ☐ Recurrent ☐ Persistent

Reason: ☐ Tapering ☐ DLI ☐ Unexplained

Date onset of this episode: ....- .... - .... ☐ Not applicable
(if new or recurrent) *yyyy mm dd*

Stage:

Skin	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Lower GI tract	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Upper GI tract	☐ 0 (none)	☐ I			
Liver	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Other site affected	☐ No	☐ Yes			

Resolution
☐ No ☐ Yes: Date of resolution: ....- .... - ....
yyyy mm dd

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

CHRONIC GRAFT VERSUS HOST DISEASE (CGVHD)

Presence of cGvHD

☐ No

☐ Yes: ☐ First episode
☐ Recurrence

Date of onset .... - .... - ....
yyyy mm dd

☐ Present continuously since last reported episode

Maximum extent during this period
☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score during this period
☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

Organs affected ☐ Skin ☐ Gut ☐ Liver ☐ Mouth
☐ Eyes ☐ Lung ☐ Other, specify ..... ☐ Unknown

☐ Resolved: Date of resolution: .... - .... - ....
yyyy mm dd

OTHER COMPLICATIONS SINCE LAST REPORT

PLEASE USE THE DOCUMENT "DEFINITIONS OF INFECTIOUS DISEASES AND COMPLICATIONS AFTER STEM CELL TRANSPLANTATION" TO FILL THESE ITEMS.

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Bacteremia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		
ARDS		
Multiorgan failure due to infection		
ENDORGAN DISEASES		
Pneumonia		

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		
Retinitis		
Other:		
		yyyy mm dd

DOCUMENTED PATHOGENS *(Use this table for guidance on the pathogens of interest)*

Type	Pathogen	Type	Pathogen
Bacteria		Viruses	
	S. pneumoniae		HSV
	Other gram positive *(i.e.: other streptococci, staphylococci, listeria …)*		VZV
			EBV
	Haemophilus influenzae		CMV
	Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)*		HHV-6
			RSV
	Legionella sp		Other respiratory virus *(influenza, parainfluenza, rhinovirus)*
	Mycobacteria sp		
	Other:		Adenovirus
Fungi			HBV
	Candida sp		HCV
	Aspergillus sp		HIV
	Pneumocystis carinii		Papovavirus
	Other:		Parvovirus
Parasites			Other: .....
	Toxoplasma gondii		
	Other:		

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

NON INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type *(Check all that are applicable for this period)*	**Yes**	**No**	**Unknown**	**Date**
Idiopathic pneumonia syndrome	☐	☐	☐	
VOD	☐	☐	☐	
Cataract	☐	☐	☐	
Haemorrhagic cystitis, non infectious	☐	☐	☐	
ARDS, non infectious	☐	☐	☐	
Multiorgan failure, non infectious	☐	☐	☐	
HSCT-associated microangiopathy	☐	☐	☐	
Renal failure requiring dialysis	☐	☐	☐	
Haemolytic anaemia due to blood group	☐	☐	☐	
Aseptic bone necrosis	☐	☐	☐	
Other: .....…… VOTCOMPS	☐			
				yyyy mm dd

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

Graft loss

☐ No:

☐ Yes:

☐ Not evaluated

Overall chimaerism:

☐ Full *(donor ≥95 %)*

☐ Mixed *(partial)*

☐ Autologous reconstitution *(recipient ≥95 %)*

☐ Aplasia

INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS.

SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE.

COPY THIS TABLE AS MANY TIMES AS NECESSARY.

Date of test	Identification of donor or Cord Blood Unit given by the centre	Number in the infusion order *(if applicable)*	Cell type on which test was performed	% Donor cells	Test used
.... - ..... - .... *yyyy mm dd*	.....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify: …….	…….. % ….. …% …….. % …….. % ….. …% …….. % …….. % ….. …% …….. % …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …… ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify: …….	…….. % ….. …% …….. % …….. % ….. …% …….. % …….. % ….. …% …….. % …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …… ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify: …….	…….. % ….. …% …….. % …….. % ….. …% …….. % …….. % ….. …% …….. % …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …… ☐ unknown

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

☐ Previously reported

☐ Yes, date of diagnosis: .... - .... - ....
yyyy mm dd

Diagnosis: ☐ AML ☐ MDS ☐ Lymphoproliferative disorder ☐ Other .....

Is this secondary malignancy a donor cell leukaemia**?** ☐ No ☐ Yes ☐ Not applicable

☐ No

ADDITIONAL DISEASE TREATMENT SINCE LAST FOLLOW UP (INCLUDES CELL THERAPY)

Was any additional treatment given for the disease indication for transplant

☐ No

☐ Yes: Start date of the additional treatment since last report: ....
yyyy mm dd

☐ Unknown

-Cell therapy

Did the disease treatment include additional cell infusions *(**excluding a new HSCT**)*

☐ No

☐ Yes: Is this cell infusion an allogeneic boost? ☐ No ☐ Yes

An allo boost is an infusion of cells from the same donor without conditioning, with no evidence of graft rejection.

Is this cell infusion an autologous boost? ☐ No ☐ Yes

⇨ **If cell infusion is <u>not</u> a boost, please complete CELLULAR THERAPY on the following page**

CELLULAR THERAPY

One cell therapy regimen is defined as any number of infusions given within 10 weeks for the same indication. If more than one regimen of cell therapy has been given since last report, copy this section and complete it as many times as necessary.

Date of first infusion: ....
yyyy mm dd

Disease status before this cellular therapy ☐ CR ☐ Not in CR ☐ Not evaluated ☐ Unknown

Source of cells: ☐ Allo ☐ Auto
(check all that apply)

Type of cells *(check all that apply)*

☐ Donor lymphocyte infusion (DLI)

☐ Mesenchymal cells

☐ Fibroblasts

☐ Dendritic cells

☐ NK cells

☐ Regulatory T-cells

☐ Gamma/delta cells

☐ Other .....

☐ Unknown

Number of cells infused by type	
Nucleated cells (/kg*) *(DLI only)*	.... - .... x 10^8 ☐ Not evaluated ☐ unknown
CD 34+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
CD 3+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
Total number of cells infused	
All cells (cells/kg*) *(non DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown

Chronological number of this cell therapy for this patient .....

Indication *(check all that apply)*

☐ Planned/protocol ☐ Treatment for disease
☐ Prophylactic ☐ Mixed chimaerism
☐ Treatment of aGvHD ☐ Treatment of cGvHD
☐ Treatment viral infection ☐ Loss/decreased chimaerism
☐ Other, specify .... ☐ Treatment PTLD, EBV lymphoma

Number of infusions within 10 weeks .....
(count only infusions that are part of same regimen and given for the same indication)

Acute Graft Versus Host Disease *(after this infusion but before any further infusion / transplant)*:

Maximum grade ☐ grade 0 (absent) ☐ grade 1 ☐ grade 2
☐ grade 3 ☐ grade 4 ☐ present, grade unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

ADDITIONAL DISEASE TREATMENT GIVEN EXCLUDING CELL INFUSION?

☐ No

☐ Yes: ☐ Preemptive / preventive *(planned before the transplant took place)*
☐ For relapse / progression or persistent disease *(not planned)*

PLEASE REPORT EVERY TREATMENT GIVEN *

			DATE STARTED		DATE ENDED		ONGOING *(tick here)*
Imatinib mesylate (Gleevec, Glivec)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Dasatinib (Sprycel)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Nilotinib (Tasigna)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Bortezomib (Velcade)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Lenalidomide (Revlimid)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Rituximab (Rituxan, mabthera)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Velafermin (FGF)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Kepivance (KGF, palifermin)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Thalidomide	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Eculizumab (Soliris)	☐ No	☐ Yes:	..... - .... -	to	.... - .... -		☐
Interferon α	☐ No	☐ Yes:	....- .... -	to	.... - .... -		☐
Other chemo/drug	☐ No	☐ Yes:	....- .... -	to	.... - .... -		☐
			yyyy mm dd		*yyyy mm dd*		

Intrathecal: ☐ No ☐ Yes

Immunosuppressive therapy

☐ No (therapy stopped)
☐ Yes (with tapering)
☐ Yes, tapering off
☐ Unknown

Radiotherapy ☐ No ☐ Yes ☐ Unknown

Other treatment ☐ No ☐ Yes, specify: .... ☐ Unknown

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

- ☐ Previously reported
- ☐ No
- ☐ Yes; date diagnosed: .... - .... - .....
  yyyy mm dd

Method of detection	Date of the assessment	Site
Cinical/haematological relapse or progression	☐ No: Date assessed ..... - ..... - ..... ☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd ☐ Not evaluated	☐ marrow ☐ blood ☐ extramedullary
Cytogenetic relapse or progression	☐ No: Date assessed ..... - ..... - ..... ☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd ☐ Not evaluated	☐ marrow ☐ blood ☐ extramedullary
Molecular relapse or progression	☐ No: Date assessed ..... - ..... - ..... DMOLREL ☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd ☐ Not evaluated	☐ marrow VRELLEU6 ☐ blood ☐ extramedullary

VRELLEU5

If Haematological relapse "*yes*"

- ☐ chronic phase
- ☐ accelerated phase
- ☐ blast crisis

- ☐ Continuous progression since transplant
- ☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

DISEASE AND PATIENT STATUS ON DATE LAST SEEN

LAST DISEASE STATUS

Method **Disease detected**

(record the most recent status and date for each method)

Clinical/haematological	☐ No ☐ Yes DISCLI DISCLID Last date evaluated ..... - ..... - ..... yyyy mm dd	☐ Not evaluated
Cytogenetic/FISH	☐ No ☐ Yes: Considered disease relapse/progression % t(9;22)+ metaphases .... **%** % t(9;22)+ cells by FISH ....**%** Last date evaluated ..... - ..... - ..... yyyy mm dd	☐ No ☐ Yes ☐ Not evaluated
Molecular DISMOL	☐ No ☐ Yes: Considered disease relapse/progression Last date evaluated ..... - ..... - ..... yyyy mm dd	☐ No ☐ Yes DISMOLDR ☐ Not evaluated DISMOLD

If Disease detected by Clinical/Haematological Method "*yes*"

☐ chronic phase

☐ accelerated phase

☐ blast crisis

*** PLEASE PHOTOCOPY/REPLICATE THIS PAGE AS OFTEN AS NECESSARY IN ORDER TO PROVIDE THE HISTORY OF ALL ASSESSMENTS SINCE LAST REPORT**

PREGNANCY AFTER HSCT

Has patient or partner become pregnant after this HSCT?

☐ No

☐ Yes: Did the pregnancy result in a live birth? ☐ No ☐ Yes ☐ Unknown

☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): …….

SURVIVAL STATUS

- ☐ Alive
- ☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

SCORE
- ☐ 100 (Normal, NED)
- ☐ 90 (Normal activity)
- ☐ 80 (Normal with effort)
- ☐ 70 (Cares for self)
- ☐ 60 (Requires occasional assistance)
- ☐ 50 (Requires assistance)
- ☐ 40 (Disabled)
- ☐ 30 (Severely disabled)
- ☐ 20 (Very sick)
- ☐ 10 (Moribund)

☐ Not evaluated
☐ Unknown

MAIN CAUSE OF DEATH *(if dead)*

- ☐ Relapse or progression
- ☐ Secondary malignancy *(including lymphoproliferative disease)*
- ☐ Transplantation related cause
- ☐ Cell therapy (non HSCT) Related Cause *(if applicable)*
- ☐ Unknown
- ☐ Other: .....

Contributory Cause of Death *(check as many as appropriate)*:

(check as many as appropriate)	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection: ☐ bacterial ☐ viral ☐ fungal ☐ parasitic ☐ unknown	☐	☐	☐
Rejection / poor graft function	☐	☐	☐
History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
Haemorrhage	☐	☐	☐
Cardiac toxicity	☐	☐	☐
Central nervous system toxicity	☐	☐	☐
Gastro intestinal toxicity	☐	☐	☐
Skin toxicity	☐	☐	☐
Renal failure	☐	☐	☐
Multiple organ failure	☐	☐	☐
Other:	☐		

ADDITIONAL NOTES IF APPLICABLE

COMMENTS .....

.....

.....

IDENTIFICATION & SIGNATURE

.....