CIC: Hospital Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

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 <u>Patient</u> 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 <u>not</u> 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 MYELOPROLIFERATIVE NEOPLASM

DIAGNOSIS

SUBCLASSIFICATION

- ☐ Primary myelofibrosis *(Chronic idiopathic myelofibrosis; fibrosis with myeloid metaplasia)*
- ☐ Polycythaemia vera
- ☐ Essential or primary thrombocythaemia
- ☐ Hyper eosinophilic syndrome (HES)
- ☐ Chronic eosinophilic leukaemia (CEL): With blastic transformation ☐ No ☐ Yes ☐ Unknown
- ☐ Chronic neutrophilic leukaemia
- ☐ Systemic mastocytosis
- ☐ Mast cell leukaemia
- ☐ Mast cell sarcoma
- ☐ MPN not otherwise specified

☐ Myeloid and lymphoid neoplasms with FGFR1 abnormalities *(Stem cell leukaemia-lymphoma syndrome, 8p11 syndrome)*

Secondary origin: ☐ Yes: Disease related to prior exposure to therapeutic drugs or radiation
☐ No
☐ Unknown

IPSS Risk score for Myelofibrosis
☐ Low risk ☐ Intermediate-1 ☐ Intermediate-2 ☐ High risk ☐ Not evaluated

CYTOGENETICS AND MOLECULAR MARKERS AT DIAGNOSIS

(INCLUDE ALL ANALYSIS BEFORE TREATMENT; DESCRIBE RESULTS OF MOST RECENT COMPLETE ANALYSIS)

Chromosome analysis (All methods including FISH)

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

Complex karyotype: ☐ No ☐ Yes ☐ Unknown
(3 or more abnormalities)

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

☐ Not done or failed ☐ Unknown

You can transcribe the complete karyotype:
.....

OR

Indicate below those abnormalities that have been **evaluated** and whether they were **Absent** or **Present**

Abn 1, specify	☐ Absent	☐ Present	☐ Not evaluated
Abn 5, specify.....	☐ Absent	☐ Present	☐ Not evaluated
Abn 7, specify	☐ Absent	☐ Present	☐ Not evaluated
trisomy 8	☐ Absent	☐ Present	☐ Not evaluated
trisomy 9	☐ Absent	☐ Present	☐ Not evaluated
Del 20	☐ Absent	☐ Present	☐ Not evaluated
Del 13	☐ Absent	☐ Present	☐ Not evaluated
Other, specify	☐ Absent	☐ Present	☐ Not evaluated

Molecular markers at diagnosis

☐ Not evaluated ☐ Absent ☐ Present ☐ Unknown

Indicate below those markers that have been **evaluated** and whether they were **Absent** or **Present**

BCR-ABL	☐ Absent	☐ Present	☐ Not evaluated	
JAK2 mutation	☐ Absent	☐ Present	☐ Not evaluated	If present: Allele burden % ……
cMPL mutation	☐ Absent	☐ Present	☐ Not evaluated	
Cal Reticulin mutation	☐ Absent	☐ Present	☐ Not evaluated	
FIP1L1-PDGFR	☐ Absent	☐ Present	☐ Not evaluated	
Other, specify……	☐ Absent	☐ Present	☐ Not evaluated	

HAEMATOLOGICAL VALUES *(at diagnosis)*

Peripheral blood

Hb (g/dL) .... ☐ Not evaluated

Platelets (10^9/L) .... ☐ Not evaluated

White Blood Cells (10^9/L) .... ☐ Not evaluated

% blasts .... ☐ Not evaluated

% monocytes .... ☐ Not evaluated

% neutrophils .... ☐ Not evaluated

Bone marrow

% blasts .... ☐ Not evaluated

Auer rods present ☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

BM INVESTIGATION *(at diagnosis)*

☐ Cytology ☐ Histology ☐ Both ☐ Not available

RESULTS

(check one box in each column)

CELLULARITY ON BM ASPIRATE / BM BIOPSY

- ☐ Acellular
- ☐ Hypocellular
- ☐ Normocellular
- ☐ Hypercellular
- ☐ Focal cellularity
- ☐ Unknown

FIBROSIS/OSTEOSCLEROSIS ON BM BIOPSY

- ☐ No
- ☐ Mild (Grade 1)
- ☐ Moderate (Grade 2)
- ☐ Severe (Grade 3)
- ☐ Not evaluable
- ☐ Unknown

CONSTITUTIONAL SYMPTOMS *(at diagnosis)*

Night sweat ☐ Yes ☐ No ☐ Unknown

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

Weight loss ☐ Yes ☐ No ☐ Unknown

CIC: Hospital Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

FIRST LINE THERAPY

If this registration pertains to a second or subsequent HSCT the therapy number should be counted since last reported transplant.

FIRST LINE THERAPY GIVEN

☐ No - *Proceed to "Subclassification & Status of Disease at HSCT"*

☐ Yes: Date started .... - .... - ....
yyyy mm dd

SUBCLASSIFICATION AT PRIMARY TREATMENT

☐ MPN (as registered at diagnosis)

☐ Transformed to myelofibrosis from PV/ET: Date of transformation ..... - ..... - .....
yyyy mm dd

☐ Transformed to AML: Date of transformation..... - ..... - .....
yyyy mm dd

TREATMENT

Chemo/drug/agent ☐ No ☐ Yes: ☐ Ara-C ☐ Hydroxyurea ☐ Thalidomide
(including GF, hormones, etc.) ☐ Androgens ☐ AML like therapy ☐ Lenalidomide
☐ Tyrosine kinase inhibitor ☐ Interferon ☐ Steroids
☐ Other, specify .....

Radiotherapy ☐ No ☐ Yes: To the spleen ☐ No ☐ Yes ☐ Unknown

Other : .....

Response: ☐ Complete remission(CR)*, date of first CR .... - .... - ....
If subsequent HSCT, indicate the date of the 1st CR after this treatment *yyyy mm dd*

☐ Never in CR

* *CR must include all three conditions:*
1. *Resolution of disease –related symptoms and signs including palpable hepato-splenomegaly*
2. *Hb >11gr/dL, Platelet >100 x10^9/L and neutrophils >1 x 10^9/L.*
3. *normal bone marrow histology, and fibrosis grade no higher than 1*

SUBCLASSIFICATION & STATUS OF DISEASE AT HSCT

TO BE EVALUATED JUST BEFORE STARTING CONDITIONING

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

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

Transfusional status at HSCT
☐ No transfusions ☐ With transfusions ☐ Never transfused

CIC: Hospital Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

SUBCLASSIFICATION AT HSCT

☐ MPN (as registered at diagnosis)

☐ Transformed to myelofibrosis from PV/ET: Date of transformation ..... - ..... - .....
yyyy mm dd

☐ Transformed to AML: Date of transformation..... - ..... - .....
yyyy mm dd

DIPSS Risk score for Myelofibrosis

☐ Low risk ☐ Intermediate-1 ☐ Intermediate-2 ☐ High risk ☐ Not evaluated

STATUS OF DISEASE AT HSCT

STATUS	**NUMBER**
Treated with chemotherapy: ☐ Primary refractory phase (no change)	
☐ Complete remission (CR)	☐ 1st ☐ 2nd ☐ 3rd or higher
☐ Improvement but no CR	
☐ Relapse (after CR)	☐ 1st ☐ 2nd ☐ 3rd or higher
☐ Progression/worse ☐ Never treated (Supportive care or treatment without chemotherapy)	

CYTOGENETICS DATA *(Within 2 months before the preparative -conditioning- regimen)*

Chromosome analysis (All methods including FISH)

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

If abnormal:

Complex karyotype: ☐ No ☐ Yes ☐ Unknown
(3 or more abnormalities)

If done: number of metaphases with abnormalities: ..... / number of metaphases examined: .....

You can transcribe the complete karyotype:
.....

OR

Indicate below those abnormalities that have been **evaluated** and whether they were **Absent** or **Present**

Abn 1	☐ Absent	☐ Present	☐ Not evaluated
Abn 5	☐ Absent	☐ Present	☐ Not evaluated
Abn 7	☐ Absent	☐ Present	☐ Not evaluated
trisomy 8	☐ Absent	☐ Present	☐ Not evaluated
trisomy 9	☐ Absent	☐ Present	☐ Not evaluated
Del 20	☐ Absent	☐ Present	☐ Not evaluated
Del 13	☐ Absent	☐ Present	☐ Not evaluated
Other, specify	☐ Absent	☐ Present	☐ Not evaluated

HAEMATOLOGICAL VALUES*(To be evaluated just before starting the preparative -conditioning- regimen)*

Peripheral blood

Hb (g/dL)	....	☐ Not evaluated
Platelets (10^9/L)	....	☐ Not evaluated
White Blood Cells (10^9/L)	....	☐ Not evaluated
% blasts	....	☐ Not evaluated
% monocytes	....	☐ Not evaluated
% neutrophils	....	☐ Not evaluated

Bone marrow

% blasts .... ☐ Not evaluated

Auer rods present ☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

BM INVESTIGATION ***(Within 2 months before the preparative -conditioning- regimen)***

☐ Cytology ☐ Histology ☐ Both ☐ Not available

RESULTS

(check one box in each column)

CELLULARITY ON BM ASPIRATE / BM BIOPSY

- ☐ Acellular
- ☐ Hypocellular
- ☐ Normocellular
- ☐ Hypercellular
- ☐ Focal cellularity
- ☐ Unknown

FIBROSIS/OSTEOSCLEROSIS ON BM BIOPSY

- ☐ No
- ☐ Mild (Grade 1)
- ☐ Moderate (Grade 2)
- ☐ Severe (Grade 3)
- ☐ Not evaluable
- ☐ Unknown

CONSTITUTIONAL SYMPTOMS *(Within 2 months before the preparative -conditioning- regimen)*

Night sweat ☐ Yes ☐ No ☐ Unknown

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

Weight loss ☐ Yes ☐ No ☐ Unknown

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

MYELOPROLIFERATIVE NEOPLASM

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 last HSCT for this patient: .... - .... - ....
yyyy mm dd

RESPONSE OF DISEASE

BEST RESPONSE AT 100 DAYS AFTER HSCT

- ☐ CR (maintained or achieved)
- ☐ Improvement but no CR
- ☐ Unknown
- ☐ Relapse / Progression
- ☐ Not evaluable

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

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**

CIC: Hospital Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

FOLLOW UP

MED-B

MYELOPROLIFERATIVE NEOPLASM

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

Resolution

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

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		

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
	Haemophilus influenzae		EBV
	Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)*		CMV
	Legionella sp		HHV-6
	Mycobacteria sp		RSV
	Other:		Other respiratory virus *(influenza, parainfluenza, rhinovirus)*
Fungi			Adenovirus
	Candida sp		HBV
	Aspergillus sp		HCV
	Pneumocystis carinii		HIV
	Other:		Papovavirus
Parasites			Parvovirus
	Toxoplasma gondii		Other: .....
	Other:		

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
(ALLOS ONLY)

Graft loss

☐ No ☐ Yes ☐ Not evaluated

Overall chimaerism ☐ Full *(donor ≥95 %)* ☐ Mixed *(partial)*
☐ Autologous reconstitution *(recipient ≥95 %)* ☐ Aplasia
☐ Not evaluated

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 THERAPIES SINCE LAST FOLLOW UP

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

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

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

Indication *(check all that apply)*

☐ Planned/protocol
☐ Prophylactic
☐ Treatment of GvHD
☐ Loss/decreased chimaerism
☐ Other, specify ....
☐ Treatment for disease
☐ Mixed chimaerism
☐ Treatment viral infection
☐ 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

-Chemo / radiotherapy

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)*

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

Chemo/drug/agent ..... ☐ Unknown
(including MoAB, vaccination, etc.)
Radiotherapy ☐ No ☐ Yes ☐ Unknown

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

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

☐ Previously reported
☐ No
☐ Yes; date diagnosed: ..... - ..... - .....
yyyy mm dd
☐ Continuous progression since transplant
☐ Unknown

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Complete Remission ☐ Relapse ☐ Progression

FIBROSIS/OSTEOSCLEROSIS ON BM BIOPSY

☐ No
☐ Mild (Grade 1)
☐ Moderate (Grade 2)
☐ Severe (Grade 3)
☐ Not evaluable
☐ Unknown

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 Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

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 *(check only one main cause)*

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

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

	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection	☐	☐	☐
bacterial	☐	☐	☐
viral	☐	☐	☐
fungal	☐	☐	☐
parasitic	☐	☐	☐
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

.....