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

Annual FOLLOW UP 2012-2014

CALM - MULTIPLE MYELOMA

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

Hospital Unique Patient Number (UPN): .....

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

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

Sex: ☐ Male ☐ Female

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

PATIENT LAST SEEN

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

Complete haematological remission obtained after the HSCT in the absence of additional disease treatment

☐ Previously reported
☐ Yes, date: ..... - ..... - .....
yyyy mm dd
☐ No
☐ Unknown

COMPLICATIONS SINCE LAST REPORT

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes:

Type	Yes	Site	Pathogen	Date
Bacteremia	☐			
Fungemia	☐			
Viremia	☐			
Parasites	☐			
Septic shock	☐			
ARDS	☐			
Multiorgan failure due to infection	☐			
Pneumonia	☐			
Hepatitis	☐			
CNS Infection	☐			
Other:	☐			

yyyy/mm/dd

NON INFECTION RELATED COMPLICATIONS

☐ No complications

☐ Yes:

Type	Yes	Date
Idiopathic pneumonia syndrome	☐	
VOD	☐	
EBV lymphoproliferative disease	☐	
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: ……..	☐	

yyyy/mm/dd

GRAFT ASSESSMENT

GRAFT LOSS (EQUIVALENT TO APLASIA IF AUTO)

☐ No

☐ Yes: Date graft loss: ..... - ..... - .....
yyyy mm dd

☐ Not evaluated

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFERATIVE DISORDER DIAGNOSED

☐ Previously reported

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

Diagnosis: ☐ AML ☐ MDS ☐ EBV lymphoproliferative disorder ☐ Other: .....

☐ No, at date of this follow-up

ADDITIONAL THERAPIES SINCE LAST FOLLOW UP

DISEASE TREATMENT

☐ No

☐ Yes: ☐ Planned *(planned before HSCT took place)*

☐ Not planned *(for relapse/progression or persistent disease)*

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

☐ Previously reported

☐ No

☐ Yes; date diagnosed: ..... - ..... - .....
yyyy mm dd

☐ Continuous progression since HSCT

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Stringent complete remission (sCR)
☐ Complete remission (CR) If sCR or CR: NUMBER OF THIS COMPLETE REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Very good PR (VGPR)
☐ PR If VGPR or PR: NUMBER OF THIS PARTIAL REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Stable disease (*no change, includes old MR)*
☐ Progression
☐ Unknown

If complete response: Date of CR: ..... - ..... - .....
yyyy *mm* *dd*

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

Plateau (**COMPLETE ONLY IF STATUS IS STABLE DISEASE OR PR**)
(not applicable for non-secretory myeloma)
☐ No ☐ Yes ☐ Unknown

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

CAUSE OF DEATH *(if dead)*

☐ Relapse or progression

☐ Secondary malignancy

☐ HSCT related cause:

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

☐ Unknown

☐ Other: .....

COMMENTS: .....

IDENTIFICATION & SIGNATURE: .....