EBMT FORM GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) ....

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

Contact person: .....

Telephone ..... Fax .....

e-mail .....

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

(optional) CIBMTR Centre # .... CIBMTR patient (recipient) Identification .....

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 ....

Registrations will not be accepted if this item is left blank

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

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

Sex: ☐ Male ☐ Female

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)*

- ☐ Acute Leukaemia
  - ☐ Myelogenous (AML)
  - ☐ Lymphoblastic (ALL)
- ☐ Secondary Acute Leukaemia
  (do not use if transformed from MDS/MPN)
- ☐ Chronic Leukaemia
  - ☐ Chronic Myeloid Leukaemia (CML)
  - ☐ Chronic Lymphocytic Leukaemia
- ☐ Lymphoma
  - ☐ Non Hodgkin
  - ☐ Hodgkin's Disease
- ☐ Myeloma /Plasma cell disorder
- ☐ Solid Tumour
- ☐ Myelodysplastic syndromes
  - ☐ MDS
  - ☐ MD/MPN
- ☐ Myeloproliferative neoplasm
- ☐ Bone marrow failure including Aplastic anaemia
- ☐ Inherited disorders
  - ☐ Primary immune deficiencies
  - ☐ Metabolic disorders
- ☐ Histiocytic disorders
- ☐ Autoimmune disease
  - ☐ Juvenile Idiopathic Arthritis
  - ☐ Multiple Sclerosis
  - ☐ Systemic Lupus
  - ☐ Systemic Sclerosis
- ☐ Haemoglobinopathy

☐ Other diagnosis, specify:_____

SPECIFICATIONS OF THE DISEASE

LYMPHOMA

INITIAL DIAGNOSIS

Has the information requested in this section been submitted with a previous transplant registration for this patient?

☐ Yes: go to page 4, *Treatment given before the 1st transplant*

☐ No: proceed with this section

☐ Non Hodgkin Lymphoma (NHL)

Mature B-cell neoplasm

- ☐ Follicular lymphoma
  - Grade ☐ I ☐ II ☐ III ☐ Not evaluated ☐ Unknown
- ☐ Mantle cell lymphoma
- ☐ Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue (MALT-lymphoma)
- ☐ Diffuse large B-cell lymphoma
  - ☐ Intravascular
  - ☐ Mediastinal
  - ☐ Primary effussion
- ☐ Burkitt lymphoma
  - ☐ High grade B-cell lymphoma, Burkitt-like *(provisional entity)*
- ☐ Lymphoplasmacytic lymphoma
- ☐ Waldenstrom macroglobulinaemia
- ☐ Splenic marginal zone lymphoma
- ☐ Nodal marginal zone B-cell lymphoma
- ☐ Primary CNS lymphoma
- ☐ Other B-cell, specify .....

Mature T-cell and NK-cell neoplasms

- ☐ Angioimmunoblastic T-cell lymphoma (AILD)
- ☐ Peripheral T-cell lymphoma, all types
- ☐ Anaplastic large cell, T/null cell, primary cutaneous
- ☐ Anaplastic large cell, T/null cell, primary systemic
- ☐ Extranodal NK/T cell lymphoma, nasal type
- ☐ Enteropathy type T-cell lymphoma
- ☐ Hepatosplenic gamma-delta T-cell lymphoma
- ☐ Subcutaneous panniculitis-like T-cell lymphoma
- ☐ Adult T-cell lymphoma/leukaemia (HTLV1+)
- ☐ Aggressive NK-cell leukaemia
- ☐ Large T-cell granular lymphocytic lymphoma
- ☐ Mycosis fungoides
- ☐ Sezary Syndrome
- ☐ Other T/NK-cell, specify ....

Transformed from another type of lymphoma

☐ No ☐ Yes ☐ Unknown

☐ Hodgkin Lymphoma

☐ Nodular lymphocyte predominant ☐ Lymphocyte rich ☐ Nodular sclerosis

☐ Mixed cellularity ☐ Lymphocyte depleted ☐ Other, specify ....

☐ Other, specify .....

STAGE AT DIAGNOSIS

ANN ARBOR STAGING FOR ADULT NON-BURKITT'S PATIENTS
MURPHY STAGE FOR BURKITT'S DISEASE AND PAEDIATRIC PATIENTS.

Stage
- ☐ I
- ☐ II
- ☐ III
- ☐ IV
- ☐ Not evaluated
- ☐ Unknown

Systemic symptoms
- ☐ Absent (A)
- ☐ Present (B)
- ☐ Not evaluated
- ☐ Unknown

DISEASE INVOLVEMENT AT DIAGNOSIS

Size of largest mass

☐ < 5 cm ☐ 5-10 cm ☐ > 10 cm ☐ No mass ☐ Unknown

LDH LEVELS

☐ Normal ☐ Elevated ☐ Not evaluated ☐ Unknown

Specific sites of involvement

☐ Nodes below the diaphragm	☐ Bone marrow	☐ Extranodal (CNS)
☐ Mediastinum	☐ Extranodal (testis /ovary)	☐ Nodes above the diaphragm
☐ Lung	☐ Liver	☐ Spleen

☐ Other : .....

TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT

Has the information requested in this section been submitted with a previous transplant registration for this patient?

☐ Yes: go to page 5, *"Disease History before HSCT"*

☐ No: proceed with this section

IF THE NUMBER OF TREATMENTS GIVEN BEFORE THE 1ST TRANSPLANT IS HIGHER THAN 3, PLEASE PHOTOCOPY THIS PAGE AS MANY TIMES AS NECESSARY TO PROVIDE INFORMATION ON ALL TREATMENTS

WAS THE PATIENT TREATED BEFORE THE 1ST TRANSPLANT PROCEDURE?

☐ No – *Proceed to page 5, "Disease History before HSCT"*

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

Sequential number of this treatment: .....
(counted from diagnosis)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, etc.) If MoAB, radiolabelled ☐ No ☐ Yes ☐ Unknown

Radiotherapy ☐ No ☐ Yes

☐ Unknown

Response to this line of therapy

☐ Complete remission ☐ Partial remission (> 50 %) ☐ No response (< 50 %)

ADDITIONAL TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT?

☐ No – *Proceed to page 5, "Disease History before HSCT"*

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

Sequential number of this treatment: .....
(counted from diagnosis)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, etc.) If MoAB, radiolabelled ☐ No ☐ Yes ☐ Unknown

Radiotherapy ☐ No ☐ Yes

☐ Unknown

Response to this line of therapy

☐ Complete remission ☐ Partial remission (> 50 %) ☐ No response (< 50 %)

ADDITIONAL TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT?

☐ No – *Proceed to page 5, "Disease History before HSCT"*

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

Sequential number of this treatment: .....
(counted from diagnosis)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, etc.) If MoAB, radiolabelled ☐ No ☐ Yes ☐ Unknown

Radiotherapy ☐ No ☐ Yes

☐ Unknown

Response to this line of therapy

☐ Complete remission ☐ Partial remission (> 50 %) ☐ No response (< 50 %)

DISEASE HISTORY BEFORE HSCT

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

TREATMENT SUMMARY

Total number of lines before this transplant …….
(since diagnosis if 1st transplant, or since last reported transplant)

Modality used at least once:	Chemotherapy	☐ No	☐ Yes	☐ Unknown
	MoAB *(Immunotherapy*)	☐ No	☐ Yes	☐ Unknown
	Radiotherapy	☐ No	☐ Yes	☐ Unknown

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

COMPLETE REMISSION AND RELAPSE HISTORY BEFORE THE 1ST HSCT

If patient did not have treatment before the 1st HSCT or the information requested in this section has been submitted with a previous registration for this patient go to page 6, *Status of disease at HSCT*

CR achieved before the 1st transplant:

☐ Yes: Date of first CR: .... - .... - ....
☐ No *yyyy mm dd*

Number of treatment lines necessary to reach this first remission: .....

Number of CR's …….

TO BE COMPLETED ONLY IF PATIENT HAD A CR BEFORE THE 1ST TRANSPLANT

1st Relapse before the 1st transplant:

☐ Yes: Date of first relapse: .. .. - .... - ....
☐ No *yyyy mm dd*

STATUS OF DISEASE AT HSCT

STATUS OF DISEASE AT HSCT

If patient has ever achieved Complete remission

☐ Complete remission (CR)
- ☐ Unconfirmed
- ☐ Confirmed: ☐ By CT scan ☐ By PET

NUMBER OF THIS REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Relapse

NUMBER OF THIS RELAPSE
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

TYPE OF RELAPSE
- ☐ Untreated (untested)
- ☐ Sensitive (responding)
- ☐ Resistant

If patient has <u>never</u> achieved a Complete remission

- ☐ At diagnosis (untreated)
- ☐ Primary refractory disease
- ☐ Very good 1st PR (> 90 %)
- ☐ PR

NUMBER OF THIS PR
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

- ☐ Progression

DISEASE INVOLVEMENT AT TRANSPLANT

☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

Size of largest mass *(if patient in CR at HSCT, indicate "No mass")*

☐ < 5 cm ☐ 5-10 cm ☐ > 10 cm ☐ No mass ☐ Not evaluated

Specific sites of disease *(to be completed ONLY if patient NOT in CR at transplant)*

☐ Nodes below the diaphragm	☐ Bone marrow	☐ Extranodal (CNS)
☐ Mediastinum	☐ Extranodal (testis /ovary)	☐ Nodes above the diaphragm
☐ Lung	☐ Liver	☐ Spleen

☐ Other : .....

ADDITIONAL TREATMENT POST-HSCT

ADDITIONAL DISEASE TREATMENT

☐ No

☐ Yes: ☐ Planned *(planned before HSCT took place)*
☐ Not planned *(for relapse/progression or persistent disease)*

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

Chemo/drug/agent ..... ☐ Unknown
(including MoAB, vaccination, etc.)

Radiotherapy ☐ No ☐ Yes ☐ Unknown

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

☐ Unknown

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

BEST RESPONSE AT 100 DAYS AFTER TRANSPLANTATION

☐ Complete remission *(maintained or achieved)*
- ☐ Unconfirmed
- ☐ Confirmed: ☐ By CT scan ☐ By PET

☐ Partial remission (> 50 %)
- ☐ Progression

☐ No response (< 50 %)
- ☐ Early death/Not evaluable

If Complete remission: Date of CR ……. - ……. - .....
yyyy mm dd

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

☐ AUTOgraft, proceed to Autograft form

☐ ALLOgraft or Syngeneic graft, proceed to Allograft form

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

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

FOLLOW UP LYMPHOMA

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

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

PATIENT LAST SEEN

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

GRAFT VERSUS HOST DISEASE (GvHD) SINCE LAST REPORT

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	☐ 1	☐ 2	☐ 3	☐ 4	☐ Not evaluated	☐ unknown
Stage liver	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ Not evaluated	☐ unknown
Stage gut	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ Not evaluated	☐ unknown

Resolution

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

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

cGvHD grade ☐ Limited ☐ Extensive

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. THE DOCUMENT IS AVAILABLE FROM www.ebmt.org, INFECTIOUS DISEASES WORKING PARTY.

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		
Hepatitis		
CNS infection		

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.*
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	☐	☐	☐	
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 AND HAEMOPOIETIC CHIMAERISM

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 ☐ EBV lymphoproliferative disorder ☐ Other .....

☐ No at date of this follow-up

ADDITIONAL THERAPIES SINCE LAST FOLLOW UP

ADDITIONAL TREATMENT

Treatment given since last report

☐ No

☐ Yes: Date started: ....
yyyy mm dd

☐ Unknown

If yes:

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.

☐ No

☐ Yes: Disease status before this cellular therapy ☐ CR ☐ Not in CR ☐ Not evaluated

☐ Unknown

If yes:

Type of cells

☐ Donor lymphocyte infusion (DLI)

☐ Mesenchymal cells

☐ Other .....

☐ Unknown

Number of cells infused by type DLI only	
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 any non DLI infusion	
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
- ☐ 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 / HSCT)*:

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

DISEASE TREATMENT *(apart from donor cell infusion or other type of cell therapy)*

☐ No

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

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

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 HSCT
- ☐ Unknown

DISEASE AND PATIENT STATUS ON DATE LAST SEEN

LAST DISEASE STATUS

- ☐ Complete Remission
- ☐ Relapse / progression

CONCEPTION

Has patient or partner become pregnant after this HSCT?

☐ Yes ☐ No ☐ 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: ..... DEACSBMR	☐		

- ☐ Unknown
- ☐ Other : .....

.....

ADDITIONAL NOTES IF APPLICABLE

COMMENTS .....

.....

.....

IDENTIFICATION & SIGNATURE

.....

_____