Off-label transplant use of plerixafor

Inclusion period: 31/07/2009 to 31/07/2014

PATIENT REGISTRATION FORM

THIS PATIENT TREATED WITH PLERIXAFOR

Please tick all that apply

- has a background disease **other than lymphoma or MM** ☐ yes ☐ no
- is **< 18 years of age** at transplant ☐ yes ☐ no
- received/receives transplant using **ex vivo plerixafor**-mobilized stem cells *(i.e. Umbilical Cord, Bone Marrow and Peripheral Blood cell collection)* ☐ yes ☐ no
- had a transplant using plerixafor-mobilised cells from **allogeneic donor** ☐ yes ☐ no
- received plerixafor **not subcutaneously** ☐ yes ☐ no
- had a transplant using plerixafor-mobilised **Bone Marrow** cells ☐ yes ☐ no
- received treatment with **plerixafor alone** *(i.e. without G-CSF)* ☐ yes ☐ no
- had a **contraindication for G-CSF** ☐ yes ☐ no

  Patient has sickle cell disease or sickle cell trait: ☐ yes ☐ no

  Other: .....
- is **NOT a poor mobiliser**: ☐ yes ☐ no

  If yes:

  ☐ Wish to maximize stem cell collection

  ☐ Other reason: .....

TEAM

CIC: |___| |___| |___| Hospital name: .....

Contact person: .....

Date of this report: ..../..... ...../..... ..... (*yyyy / mm / dd*)

PATIENT

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

Hospital Unique Patient Number.....

Date of birth: ..../..... ...../..... ..... (*yyyy / mm / dd*)

Date of HSCT: ..../..... ...../..... ..... (*yyyy / mm / dd*)

ADDITIONAL NOTES IF APPLICABLE

Comments: .....

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IDENTIFICATION & SIGNATURE

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