EBMT FORM GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) .... CIBMTR Centre # ....

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

PLASMA CELL DISORDERS (INCLUDING MULTIPLE MYELOMA)

INITIAL DIAGNOSIS

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

☐ Yes: go to page 3, *Pre HSCT Treatment* ☐ No: proceed with this section

SUBCLASSIFICATION

	Heavy Chain	Light Chain
Select one	*Select one as applicable*	*Select one as applicable*
☐ Multiple myeloma	☐ IgG	☐ Kappa
☐ Heavy chain and light chain *(check light and heavy chain types)* →	☐ IgA	☐ Lambda
☐ Light chain only *(check light chain type only)* →	☐ IgD	
☐ Non secretory	☐ IgE	
	☐ IgM	
☐ Plasma Cell Leukaemia		
☐ Solitary plasmacytoma		
☐ Other		

STAGE AT DIAGNOSIS

Complete both staging systems

SALMON AND DURIE

	I	II	III
A	☐	☐	☐
B	☐	☐	☐

ISS

	β2 µglob *(mg/L)*	Albumin *(g/L)*
☐ **I**	<3.5	≥35
☐ **II**	<3.5	<35
	3.5 – ≤5.5	--------
☐ **III**	>5.5	--------

CYTOGENETICS AND MOLECULAR DATA

Chromosome analysis

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

Number of metaphases with anomalies: ..... / number of metaphases examined: .....

If abnormal, indicate abnormalities found:

del 13q	☐ Absent	☐ Present
abn 17q	☐ Absent	☐ Present
t(4;14)	☐ Absent	☐ Present

☐ Other or associated abnormalities (specify).....

.....

Molecular analysis

☐ Done but failed ☐ Done, successful ☐ Not evaluated ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)*	....	☐ Not evaluated
Serum creatinine *(µmol/L)*	....	☐ Not evaluated
Serum calcium *(mmol/L)*	.... -	☐ Not evaluated
Serum albumin *(g/L)*	....	☐ Not evaluated
BM aspirate: % plasmacytosis	....	☐ Not evaluated
BM trephine: % plasmacytosis	....	☐ Not evaluated
Monoclonal Ig in serum *(g/L)*	....	☐ Not evaluated
Monoclonal Ig in urine *(g/24 h)*	....	☐ Not evaluated
Serum β2 microglobulin *(mg/L)*	.... -	☐ Not evaluated

INVOLVEMENT AT DIAGNOSIS

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

Extramedullary involvement ☐ No ☐ Yes, specify location ..... ☐ Unknown

PRE-HSCT TREATMENT

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

WAS THE PATIENT TREATED BEFORE THE HSCT PROCEDURE?

☐ No

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

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*

☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No

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

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*

☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No

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

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*

☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

HSCT

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

HSCT TYPE

☐ Allogeneic: *Proceed to* STATUS OF DISEASE AT START OF CONDITIONING *on page 5*

☐ Autologous: Date of 1st collection or pheresis: .... - .... - ....
yyyy mm dd

STATUS OF DISEASE AT COLLECTION (AUTOGRAFTS ONLY)

IMMEDIATELY PRIOR TO MOBILISING CHEMOTHERAPY AND/OR GROWTH FACTOR IF USED

SEE MANUAL FOR FULL DEFINITION OF EACH DISEASE STATUS

☐ At diagnosis *(untreated)*

☐ 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

☐ Relapse from CR *(untreated after the relapse)* NUMBER OF THIS RELAPSE
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

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

☐ Progression

☐ Unknown

Plateau (**COMPLETE ONLY IF STATUS IS STABLE DIEASE OR PR**)
(not applicable for non secretory myelona)

☐ No ☐ Yes ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)* .... ☐ Not evaluated

Serum creatinine *(μmol/L)* .... ☐ Not evaluated

Serum calcium *(mmol/L)* .... - .... ☐ Not evaluated

Serum albumin *(g/L)* .... ☐ Not evaluated

BM aspirate: % plasmacytosis .... ☐ Not evaluated

BM trephine: % plasmacytosis .... ☐ Not evaluated

Monoclonal Ig in serum *(g/L)* .... ☐ Not evaluated

Immunofixation of serum ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Monoclonal Ig in urine *(g/24 h)* .... ☐ Not evaluated

Immunofixation of urine ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Serum β2 microglobulin *(mg/L)* .... - ..... ☐ Not evaluated

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

DISEASE STATUS AT HSCT

To be evaluated just before starting conditioning

SEE MANUAL FOR FULL DEFINITION OF EACH DISEASE STATUS

☐ At diagnosis *(untreated)*

☐ 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

☐ Relapse from CR *(untreated after the relapse)* NUMBER OF THIS RELAPSE
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

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

☐ Progression

☐ Unknown

Plateau (**COMPLETE ONLY IF STATUS IS STABLE DIEASE OR PR**)
(not applicable for non secretory myelona)

☐ No ☐ Yes ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)* .... ☐ Not evaluated

Serum creatinine *(μmol/L)* .... ☐ Not evaluated

Serum calcium *(mmol/L)* .... - .... ☐ Not evaluated

Serum albumin *(g/L)* .... ☐ Not evaluated

BM aspirate: % plasmacytosis .... ☐ Not evaluated

BM trephine: % plasmacytosis .... ☐ Not evaluated

Monoclonal Ig in serum *(g/L)* .... ☐ Not evaluated

Immunofixation of serum ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Monoclonal Ig in urine *(g/24 h)* .... ☐ Not evaluated

Immunofixation of urine ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Serum β2 microglobulin *(mg/L)* .... - ..... ☐ Not evaluated

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

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 : ☐ Thalidomide
(including MoAB, etc.) ☐ Other ..... ☐ Unknown

Radiotherapy ☐ No ☐ Yes ☐ Unknown

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

☐ Unknown

STATUS OF DISEASE AT 100 DAYS AFTER HSCT

If patient died before 100 days, please proceed to FORMS TO BE FILLED IN on page 7.

BEST RESPONSE TO HSCT AT 100 DAYS

(see manual for full definition of each response)

- ☐ 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 myelona)
☐ No ☐ Yes ☐ Unknown

CLINICAL AND LABORATORY DATA

BM aspirate: % plasmacytosis	....		☐ Not evaluated	
BM trephine: % plasmacytosis	....		☐ Not evaluated	
Monoclonal Ig in serum *(g/L)*	....		☐ Not evaluated	
Immunofixation of serum	☐ Negative	☐ Positive	☐ Not evaluated	☐ Unknown
Monoclonal Ig in urine *(g/24 h)*	....		☐ Not evaluated	
Immunofixation of urine	☐ Negative	☐ Positive	☐ Not evaluated	☐ Unknown
Serum β2 microglobulin *(mg/L)*	.... -		☐ Not evaluated	

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF HSCT *(CHECK ALL THAT APPLY)*:

- ☐ AUTOgraft, proceed to Autograft form
- ☐ ALLOgraft or Syngeneic graft, proceed to Allograft form
  - If ☐ Cord Blood, fill in also section in Forms Appendix
  - If ☐ Other : ..... , contact the EBMT Central Office for instructions

FOLLOW UP PLASMA CELL DISORDERS (INCLUDING MULTIPLE MYELOMA)

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)*

Hospital Unique Patient Number .....

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

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

Name of study / trial .....

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

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

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

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 HSCT" 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		

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	☐	☐	☐	
TTP / HUS	☐	☐	☐	
Renal failure requiring dialysis	☐	☐	☐	
Result of blood group incompatibility	☐	☐	☐	
Aseptic bone necrosis	☐	☐	☐	
Other: .....……	☐			

yyyy mm dd

COMMENTS .....

.....

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	
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 GvHD ☐ Treatment viral infection

☐ Loss/decreased chimaerism ☐ Treatment PTLD, EBV lymphoma

☐ Other, specify ....

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)*

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

☐ Complete Remission
☐ Stable disease
☐ 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

.....

_____