

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
 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 Sex: Male Female
yyyy mm dd
 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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Acute Leukaemia
<input type="checkbox"/> Myelogenous (AML)
<input type="checkbox"/> Lymphoblastic (ALL)
<input type="checkbox"/> Secondary Acute Leukaemia
<i>(do not use if transformed from MDS/MPS)</i>
<input type="checkbox"/> Chronic Leukaemia
<input type="checkbox"/> Chronic Myeloid Leukaemia (CML)
<input type="checkbox"/> Chronic Lymphocytic Leukaemia
<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Non Hodgkin
<input type="checkbox"/> Hodgkin's Disease
<input type="checkbox"/> Other diagnosis, specify: _____ | <input type="checkbox"/> Myeloma /Plasma cell disorder
<input type="checkbox"/> Solid Tumour
<input type="checkbox"/> Myelodysplastic syndromes
<input type="checkbox"/> MDS
<input type="checkbox"/> MD/MPS
<input type="checkbox"/> Myeloproliferative syndrome
<input type="checkbox"/> Aplastic anaemia
<input type="checkbox"/> Inherited disorders
<input type="checkbox"/> Primary immune deficiencies
<input type="checkbox"/> Metabolic disorders | <input type="checkbox"/> Hystiocytic disorders
<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/> Juvenile Idiopathic Arthritis
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Systemic Sclerosis
<input type="checkbox"/> Haemoglobinopathy |
|--|---|--|

SPECIFICATIONS
OF THE DISEASE

PRIMARY ACUTE LEUKAEMIA

INITIAL DIAGNOSIS

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

- Yes: go to page 6, *Type of HSCT*
- No: proceed with this section

DIAGNOSIS

- Acute Myelogenous Leukaemia (AML)**
(non-lymphoblastic)
- Acute Lymphoblastic Leukaemia (ALL)**
- Acute Biphenotypic Leukaemia**
- Other, specify:**

WHO CLASSIFICATION AT DIAGNOSIS OF DE NOVO AML

Acute myeloid leukaemia with recurrent genetic abnormalities:

- Acute myeloid leukaemia with t(8;21)(q22;q22), (*AML1/ETO*)
- Acute myeloid leukaemia with abnormal bone marrow eosinophils and inv(16)(p13q22) or t(16;16)(p13;q22) *CBFβ/MYH11*
- Acute myeloid leukaemia with t(15;17)(q22;q12), (*PML/RARα*) and variants
- Acute myeloid leukaemia with 11q23, (*MLL*) abnormalities
- Acute with multilineage dysplasia in at least 50% of cells in 2 or more myeloid lineages without antecedent MDS or MPS/MDS

Acute myeloid leukaemia, not otherwise categorized, classify as:

- Acute myeloid leukaemia, minimally differentiated
- Acute myeloid leukaemia without maturation
- Acute myeloid leukaemia with maturation
- Acute myelomonocytic leukaemia
- Acute monoblastic/acute monocytic leukaemia
- Acute erythroid leukaemia (erythroid/myeloid and pure erythroleukaemia)
- Acute megakaryoblastic leukaemia
- Acute basophilic leukaemia
- Acute panmyelosis with myelofibrosis
- Myeloid sarcoma

- Acute myeloid leukaemia not otherwise specified or other

WHO CLASSIFICATION AT DIAGNOSIS OF DE NOVO ALL

- Precursor B-cell ALL
 - Indicate cytogenetic subtype:
 - t(9;22)(a34;q11); BCR/ABL
 - t(v;11q23); MLL rearranged
 - t(1;19)(q23;p13) E2A/PBX1
 - t(12;21)(p12;q22) ETV/CBF-alpha
- Precursor T-cell ALL

ALL not otherwise specify or other

PLEASE, COMPLETE ALSO THE IMMUNOLOGICAL CLASSIFICATION OF ALL BELOW

IMMUNOLOGICAL CLASSIFICATION FOR ALL

(NA stands for "not available")

Subgroup			
B- Lineage ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<i>B- Precursor ALL</i>			
Pro B-ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Common ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Pre-B-ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<i>Mature B-ALL</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
T- Lineage ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Early T-ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Mature T-ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Thymic T-ALL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

CD markers frequently used in ALL classification
HLA-DR ⁺ , TdT ⁺ , CD19 ⁺ and/or CD79a ⁺ and/or CD22 ⁺
CD10 ⁻ , CD24 [±] , CD20 ⁻
CD10 ⁺ , CD24 ⁺ , CD20 [±]
CD10 ⁺ , CD24 ⁺ , CD20 [±] , cyIg ⁺
CD10 ⁺ , CD24 ⁺ , CD20 ⁺ , cyIg ⁺ , sIg ⁺
CD7 ⁺ , cyCD3 ⁺
CD2 [±] , CD1a ⁻ , sCD3 ⁻ , CD5 [±] , CD4 ⁻ , CD8 [±]
CD2 ⁺ , CD1a ⁻ , sCD3 ⁺ , CD5 ⁺ , CD4 [±] , CD8 [±]
CD2 ⁺ , CD1a ⁺ , sCD3 [±] , CD5 ⁺ , CD4 [±] , CD8 [±]

Other, specify:

SECONDARY ORIGIN

- No
- Yes, evolution of MDS
- Yes, disease related to prior exposure to therapeutic drugs or radiation (treatment for previous malignancies)

If the answer to this question is "Yes" for any reason, do not complete this form; instead complete the MYELODYSPLASTIC SYNDROME or MDS+MPS or SECONDARY ACUTE LEUKAEMIA form

CYTOGENETICS

Chromosome analysis

Not done or failed Done: normal Done: abnormal Unknown

If abnormal: Are there 3 or more abnormalities (*complex karyotype*)? No Yes unknown

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

Indicate which abnormalities found:

hypodiploid (<46)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present: number of chromosomes
hyperdiploid (>46)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present: number of chromosomes
pseudodiploid	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
t(9;22)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
t(4;11)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
inv (16)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
t(15;17)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
t(8;21)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
abn 5	<input type="checkbox"/> Absent	<input type="checkbox"/> Present: specify
other abn 11q	<input type="checkbox"/> Absent	<input type="checkbox"/> Present: specify
t(12;21)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
t(1;19)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
trisomy 8	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
monosomy 7	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
other abn 7	<input type="checkbox"/> Absent	<input type="checkbox"/> Present: specify

Other or associated abnormalities (specify, including whether absent or present)

MOLECULAR BIOLOGY

Molecular markers : Evaluated: Absent Evaluated: Present
 Not evaluated unknown

Fill in table below if at all evaluated:

BCR-ABL	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
PML-RAR	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
AML1-ETO	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
FLT3-ITD (<i>internal tandem duplication</i>)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
CEBPA mutation	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
NPM1 mutation	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
MLL-PTD (<i>partial tandem duplication</i>)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> unknown
Other, specify	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	

White blood cell count at diagnosis (10⁹/l) : Not available / unknown

INVOLVEMENT AT DIAGNOSIS

Bone marrow	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
CNS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Testis/ovary	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Chloroma (<i>AML only</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No:	<input type="checkbox"/> Yes		

FIRST LINE THERAPY

FIRST LINE THERAPY GIVEN

- No
 Yes: IF DIAGNOSIS IS ACUTE MYELOBLASTIC LEUKAEMIA, SKIP QUESTION BELOW AND GO TO **DATE OF HSCT**

Date started :
yyyy mm dd

Tyrosine kinase receptor antagonist given

FILL IN ONLY FOR ACUTE LYMPHOBLASTIC LEUKAEMIA

- No
 Yes: Imatinib
 Dasatinib
 Other, specify

Date started :
yyyy mm dd

Date ended
(Enter last date given including today if ongoing) yyyy mm dd

Tick here if ongoing

DATE OF HSCT

DATE OF HSCT :
yyyy mm dd

DISEASE HISTORY BEFORE 1ST HSCT

FILL IN THIS SECTION ONLY IF THIS IS THE FIRST HSCT FOR THIS DISEASE FOR THIS PATIENT. OTHERWISE, SKIP THIS SECTION AND GO TO TYPE OF HSCT

FIRST REMISSION SINCE DIAGNOSIS AND BEFORE THE 1ST HSCT

FILL IN FOR ALL ACUTE LEUKAEMIA DIAGNOSES

Achieved: No
 Yes: Date of first remission:
yyyy mm dd

Number of induction course(s) necessary to reach this first remission:

FIRST RELAPSE SINCE DIAGNOSIS AND BEFORE THE 1ST HSCT

FILL IN ONLY IF PATIENT HAD A CR PRIOR TO THIS HSCT

Relapsed: No
 Yes: Date of first relapse:
yyyy mm dd

Site of relapse :

Bone marrow	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
CNS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Testis/ovary	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Chloroma (AML only)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No.	<input type="checkbox"/> Yes:		

TYPE OF HSCT

HSCT TYPE Allogeneic: *Proceed to Status of disease at HSCT on page 7*
 Autologous

TREATMENT AND STATUS OF DISEASE AT STEM CELL COLLECTION

AUTOGRAFTS ONLY

DATE OF COLLECTION:
yyyy mm dd

TREATMENT

Number of chemotherapy course(s) from last CR to stem cell collection:
(fill in only if patient had a CR prior to this HSCT)

Number of chemotherapy course(s) from collection to HSCT:

DISEASE

Hematological status (considering number of blasts in bone marrow)

- Initial diagnosis / Untreated
- Primary induction failure
- Complete Remission Number of this remission 1st
 2nd
 3rd or higher

- Relapse Number of this relapse 1st
 2nd
 3rd or higher

TO BE COMPLETED ONLY IF PATIENT IN COMPLETE HAEMATOLOGICAL REMISSION

- Complete cytogenetic remission**
(fill in only if cytogenetic abnormality/ies detected at diagnosis)
- No: Persistence of previously detected abnormality/ies
 - Yes: Absence of previously detected abnormality/ies
 - Not Done / Not available

- Complete molecular remission**
(fill in only if molecular abnormality/ies detected at diagnosis)
- No: Persistence of previously detected abnormality/ies
 - Yes: Absence of previously detected abnormality/ies
 - Not Done / Not available

STATUS OF DISEASE AT HSCT

STATUS OF DISEASE AT HSCT

Hematological status (considering number of blasts in bone marrow)

- Initial diagnosis
- Primary induction failure
- Complete Remission Number of this remission 1st
 2nd
 3rd or higher

- Relapse Number of this relapse 1st
 2nd
 3rd or higher

TO BE COMPLETED ONLY IF PATIENT IN COMPLETE REMISSION

- Complete cytogenetic remission**
(fill in only if cytogenetic abnormality/ies detected at diagnosis)
- No: Persistence of previously detected abnormality/ies
 - Yes: Absence of previously detected abnormality/ies
 - Not Done / Not available

- Complete molecular remission**
(fill in only if molecular abnormality/ies detected at diagnosis)
- No: Persistence of previously detected abnormality/ies
 - Yes: Absence of previously detected abnormality/ies
 - Not Done / Not available

ADDITIONAL TREATMENT POST-HSCT

ADDITIONAL DISEASE TREATMENT

- No
- Yes: Planned *(planned before HSCT took place)*
 Not planned *(for relapse/progression or persistent disease)*

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

BEST RESPONSE AT 100 DAYS AFTER HSCT

- CR (maintained or achieved) If complete response: date of CR
yyyy mm dd
- Relapse / progression Not evaluable
- Death Unknown

FORMS TO BE FILLED IN

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

FOLLOW UP	PRIMARY ACUTE LEUKAEMIA
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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

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 <i>Use the list of pathogens listed after this table for guidance. Use "unknown" if necessary.</i>	Date <i>Provide different dates for different episodes of the same complication if applicable.</i>
Bacteremia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		
ARDS		

Type	Pathogen <i>Use the list of pathogens listed after this table for guidance. Use "unknown" if necessary.</i>	Date <i>Provide different dates for different episodes of the same complication if applicable.</i>
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	S. pneumoniae	Viruses	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	Candida sp		Adenovirus
	Aspergillus sp		HBV
	Pneumocystis carinii		HCV
	Other:		HIV
			Papovavirus
Parasites	Toxoplasma gondii		Parvovirus
	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EBV lymphoproliferative disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haemorrhagic cystitis, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ARDS, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiorgan failure, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transplant-associated microangiopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Renal failure requiring dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haemolytic anaemia due to blood group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aseptic bone necrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>			

yyyy mm dd

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

GRAFT LOSS (EQUIVALENT TO APLASIA IF AUTO)

- No: If allo: Date graft assessed - -
yyyy mm dd
Chimaerism: Full Mixed: % donor cells
- Method used for chimaerism: FISH Molecular
(check all that apply) Cytogenetic ABO Group
- Yes: Date graft loss - -
yyyy mm dd
If allo: Aplasia Autologous reconstitution
- Not evaluated

CHRONIC GRAFT VERSUS HOST DISEASE (cGVHD)

(allografts only)

Presence of cGVHD

- No
 Yes: First episode
 Recurrence
Date of onset of this episode: - -
yyyy mm dd
- Present continuously since last reported episode
- cGVHD grade Limited Extensive
- Organs affected Skin Gut Liver Mouth
 Eyes Other, specify Unknown
- Resolved: Date of resolution: - -
yyyy mm dd

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

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 <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
CD 34+ (cells/kg*) (DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
CD 3+ (cells/kg*) (DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
Total number of cells infused	
All cells (cells/kg*) (non DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> 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 / transplant):

- 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

Method of detection	Date of the assessment	Site
Clinical/haematological relapse or progression	<input type="checkbox"/> No: Date assessed - - yyyy mm dd	
	<input type="checkbox"/> Yes: Date first seen - - yyyy mm dd	<input type="checkbox"/> marrow – blood <input type="checkbox"/> extramedullary
	<input type="checkbox"/> Not evaluated	
Cytogenetic relapse or progression	<input type="checkbox"/> No: Date assessed - - yyyy mm dd	
	<input type="checkbox"/> Yes: Date first seen - - yyyy mm dd	<input type="checkbox"/> marrow – blood <input type="checkbox"/> extramedullary
	<input type="checkbox"/> Not evaluated	
Molecular relapse or progression	<input type="checkbox"/> No: Date assessed - - yyyy mm dd	
	<input type="checkbox"/> Yes: Date first seen - - yyyy mm dd	<input type="checkbox"/> marrow – blood <input type="checkbox"/> extramedullary
	<input type="checkbox"/> Not evaluated	

- Continuous progression since transplant
 Unknown

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

- Complete Remission
 Stable disease
 Relapse
 Progression

Method	Disease detected
<i>(record the most recent status and date for each method)</i>	
Clinical/haematological	<input type="checkbox"/> No <input type="checkbox"/> Yes Last date evaluated - - yyyy mm dd
	<input type="checkbox"/> Not evaluated
Cytogenetic/FISH	<input type="checkbox"/> No <input type="checkbox"/> Yes: Considered disease relapse/progression
	<input type="checkbox"/> No <input type="checkbox"/> Yes Last date assessed - - yyyy mm dd
	<input type="checkbox"/> Not evaluated
Molecular	<input type="checkbox"/> No <input type="checkbox"/> Yes: Considered disease relapse/progression
	<input type="checkbox"/> No <input type="checkbox"/> Yes Last date assessed - - yyyy mm dd
	<input type="checkbox"/> Not evaluated

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial pneumonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary toxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> bacterial <input type="checkbox"/> viral <input type="checkbox"/> fungal <input type="checkbox"/> parasitic <input type="checkbox"/> unknown			
Rejection / poor graft function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veno-Occlusive disease (VOD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac toxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central nervous system toxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastro intestinal toxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin toxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple organ failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EBV lymphoproliferative disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: DEACSBMR	<input type="checkbox"/>		

- Unknown
- Other :

ADDITIONAL NOTES IF APPLICABLE

COMMENTS

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.....

IDENTIFICATION & SIGNATURE

.....
