

# 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

UBMID (only if data is to be sent to CIBMTR): .....

### 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 .....

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

SPECIFICATIONS  
OF THE DISEASE**MYELOYDYSPLASTIC SYNDROME (MDS) OR  
MYELODISPLASTIC/MYELOPROLIFERATIVE  
NEOPLASM (MD/MPN) OR  
SECONDARY ACUTE LEUKAEMIA**

## INITIAL DIAGNOSIS

 **MYELOYDYSPLASTIC SYNDROME** *Please use the WHO subclassification if possible***(WHO) Subclassification**

- Refractory anaemia (without ring sideroblasts)
- RA with ring sideroblasts (RARS)
- RA with excess of blasts (RAEB-1)
- RA with excess of blasts (RAEB-2)
- Refractory cytopenia with multilineage dysplasia (RCMD)
- Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS)
- MDS associated with isolated del(5q)
- Unclassified (MDS-U)

**(FAB) Subclassification**

- RA without ring sideroblasts (RA)
- RA with ring sideroblasts (RARS)
- RA with excess of blasts (RAEB)
- RAEB in transformation (RAEB-t)
- Unclassified

 **MYELOYDYSPLASTIC/MYELOPROLIFERATIVE NEOPLASM**

- Chronic Myelomonocytic Leukaemia (CMML, CMML)
  - Type I  Type II
- Juvenile Myelomonocytic Leukaemia (JMML, JMML, JMML, JMML)

**SECONDARY ACUTE LEUKAEMIA** *(Related to prior treatment and not after a previous diagnosis of MDS or MPS)* **Acute Myelogenous Leukaemia (AML)****SECONDARY ORIGIN**

- No  Unknown

 Yes *(it Secondary Acute Leukaemia, it must always be Yes)*

- Cause  Chemoth./ Radioth. treated disease:  Alkylating agent/radiation-related  
*(tick all that apply)*  Topoisomerase II inhibitor-related  
 Radiation  
 Unknown
- Immune suppression
  - After stem cell HSCT
  - Other : .....
  - Unknown

Primary disease

Date of diagnosis of the primary disease: ..... - ..... - .....

yyyy mm dd

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> AML          | <input type="checkbox"/> ALL               | <input type="checkbox"/> CML              | <input type="checkbox"/> Other chronic leukaemia    |
| <input type="checkbox"/> NHL          | <input type="checkbox"/> Hodgkin's disease | <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Other plasma cell disorder |
| <input type="checkbox"/> Solid tumour | <input type="checkbox"/> Aplastic anaemia  | <input type="checkbox"/> PNH              | <input type="checkbox"/> Inherited disorder         |
| <input type="checkbox"/> Autoimmune   | <input type="checkbox"/> Other .....       | <input type="checkbox"/> unknown          |   |

**CYTOGENETICS DATA**

(INCLUDE ALL ANALYSIS BEFORE TREATMENT; DESCRIBE RESULTS OF MOST RECENT COMPLETE ANALYSIS)

**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:

Abn -Y	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 5q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Other abn 5	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 20q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 7q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Other abn 7	<input type="checkbox"/> Absent	<input type="checkbox"/> Present

Other abnormalities, specify .....

**HAEMATOLOGICAL VALUES (at diagnosis)**

**Peripheral blood**

Hb (g/dL) .....  Not evaluated  
 Platelets (10<sup>9</sup>/L) .....  Not evaluated  
 White Blood Cells (10<sup>9</sup>/L) .....  Not evaluated  
 % blasts .....  Not evaluated  
 % monocytes .....  Not evaluated  
 % neutrophils .....  Not evaluated

**Bone marrow**

% blasts .....  Not evaluated  
 Auer rods present  Yes  No  Not evaluated  Unknown

**IPSS score (Fill only for MDS and CMML; do not fill for treatment related secondary Acute leukaemia, or JMML)**

Low (0)  Intermediate-1 (0.5-1.0)  Intermediate-2 (1.5)  High (>1.5)  Unknown

**BM INVESTIGATION**

Cytology  Histology  Not available

**RESULTS**

(at diagnosis; check one box in each column)

CELLULARITY ON BM ASPIRATE / BM BIOPSY	FIBROSIS ON BM BIOPSY
<input type="checkbox"/> Acellular	<input type="checkbox"/> No
<input type="checkbox"/> Hypocellular	<input type="checkbox"/> Mild
<input type="checkbox"/> Normocellular	<input type="checkbox"/> Moderate
<input type="checkbox"/> Hypercellular	<input type="checkbox"/> Severe
<input type="checkbox"/> Focal cellularity	<input type="checkbox"/> Not evaluable
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

## FIRST LINE THERAPY

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

### FIRST LINE THERAPY GIVEN

- No - Proceed to page 4, "Subclassification & Status of Disease at HSCT"
- Yes: Date started ..... - ..... - .....  
 yyyy mm dd

### SUBCLASSIFICATION AT PRIMARY TREATMENT

*If patient had Secondary Acute Leukaemia related to prior treatment, skip this Subclassification section and proceed to Treatment section*

- MYELODYSPLASTIC SYNDROME** Please, use the WHO subclassification if possible

#### (WHO)Subclassification

- Refractory anaemia (without ring sideroblasts)
- RA with ring sideroblasts (RARS)
- RA with excess of blasts (RAEB-1)
- RA with excess of blasts (RAEB-2)
- Refractory cytopenia with multilineage dysplasia (RCMD)
- Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS)
- MDS associated with isolated del(5q)
- Transformed into acute leukaemia (*Secondary acute leukaemia*)
- Unclassifiable (MDS-U)

#### (FAB)Subclassification

- RA without ring sideroblasts (RA)
- RA with ring sideroblasts (RARS)
- RA with excess of blasts (RAEB)
- RAEB in transformation (RAEB-t)
- Transformed into acute leukaemia (*Secondary acute leukaemia*)
- Unclassifiable

- MYELODYSPLASTIC/MYELOPROLIFERATIVE NEOPLASM**

- CMML
  - Type I  Type II
- JMML, same as at diagnosis
- Transformed into acute leukaemia (*Secondary acute leukaemia*)

If transformed into Secondary acute leukaemia, date of transformation: ..... - ..... - .....  
 yyyy mm dd

### TREATMENT

- Chemo/drug/agent  No  Yes:  Ara-C  Hydroxyurea  Retinoic acid  
*(including GF, hormones, etc.)*  Hypomethylating agents  Histone deacetylase Inhibitor  
 AML like therapy  Other, specify .....
- Other : .....

- Response:**  Complete remission, date of first CR ..... - ..... - .....  
*If subsequent HSCT, indicate the date of the 1<sup>st</sup> CR after this treatment* yyyy mm dd
- Never in CR

## SUBCLASSIFICATION & STATUS OF DISEASE AT HSCT

TO BE EVALUATED JUST BEFORE STARTING CONDITIONING

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

JMML ONLY: FILL IN SPLENECTOMY DETAILS

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

**TRANSFUSIONS** Red Blood Cells  No  Yes, number:  < 20 units  Unknown  
(erythrocytes)  20-50 units  
 > 50 units

Platelets  No  Yes  Unknown

### SUBCLASSIFICATION AT HSCT

If patient had Secondary Acute Leukaemia related to prior treatment, skip this section and proceed to page 5, "Disease status at HSCT"

**MYELODYSPLASTIC SYNDROME** Please, use the WHO subclassification if possible

#### (WHO)Subclassification

- Refractory anaemia (without ring sideroblasts)
- RA with ring sideroblasts (RARS)
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- RA with excess of blasts (RAEB-2)
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#### (FAB)Subclassification

- RA without ring sideroblasts (RA)
- RA with ring sideroblasts (RARS)
- RA with excess of blasts (RAEB)
- RAEB in transformation (RAEB-t)
- Transformed into acute leukaemia (*Secondary acute leukaemia*)
- Unclassifiable

**MYELODYSPLASTIC/MYELOPROLIFERATIVE NEOPLASM**

- CMML
  - Type I  Type II
- jMML, same as at diagnosis
- Transformed into acute leukaemia (*Secondary acute leukaemia*)

If transformed into Secondary acute leukaemia, date of transformation: .....  
yyyy mm dd

**DISEASE STATUS AT HSCT**

**FOR ALL DIAGNOSIS EXCEPT JMML** (see below for JMML)

Treated with intention to achieve remission:

- Primary refractory phase (no change) **NUMBER** (complete for CR or relapse)
- Complete remission (CR)  1<sup>st</sup>
- Improvement but no CR  2<sup>nd</sup>
- Relapse (after CR)  3<sup>rd</sup> or higher
- Progression/worse
- Untreated (Supportive care or treatment without intention to achieve remission)

**FOR JMML ONLY**

- Complete remission
- Partial remission
- Minor response
- Stable disease
- Progressive disease

**CYTOGENETICS DATA** (Within 2 months of the preparative -conditioning- regimen)

**Chromosome analysis**

- Not done or failed  Done: normal  Done: abnormal  Unknown

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

Indicate which abnormalities found:

Abn -Y	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 5q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Other abn 5	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 20q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Abn 7q-	<input type="checkbox"/> Absent	<input type="checkbox"/> Present
Other abn 7	<input type="checkbox"/> Absent	<input type="checkbox"/> Present

Other abnormalities, specify .....

**HAEMATOLOGICAL VALUES** (To be evaluated just before starting the preparative -conditioning- regimen)

**Peripheral blood**

- Hb (g/dL) .....  Not evaluated
- Platelets (10<sup>9</sup>/L) .....  Not evaluated
- White Blood Cells (10<sup>9</sup>/L) .....  Not evaluated
- % blasts .....  Not evaluated
- % monocytes .....  Not evaluated
- % neutrophils .....  Not evaluated

**Bone marrow**

- % blasts .....  Not evaluated
- Auer rods present  Yes  No  Not evaluated  Unknown

**IPSS score** (Fill only for MDS and CMML)

- Low (0)  Intermediate-1 (0.5-1.0)  Intermediate-2 (1.5)  High (>1.5)  Unknown

**BM INVESTIGATION** (Within 2 months of the preparative -conditioning- regimen)

- Cytology                       Histology                       Not available

**RESULTS**

(at HSCT; check one box in each column)

**CELLULARITY ON BM ASPIRATE / BM BIOPSY**

- Acellular
- Hypocellular
- Normocellular
- Hypercellular
- Focal cellularity
- Unknown

**FIBROSIS ON BM BIOPSY**

- No
- Mild
- Moderate
- Severe
- Not evaluable
- Unknown

**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 :  No     Yes, specify: .....                       Unknown  
 (including MoAB, etc.)

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

Unknown

**BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT**

**BEST RESPONSE AT 100 DAYS AFTER HSCT**

- CR (maintained or achieved)                       Unknown
- Relapse / progression                                       Not evaluable

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

FOLLOW UP	MYELODYSPLASTIC SYNDROME (MDS) OR MYELODISPLASTIC/MYELOPROLIFERATIVE NEOPLASM (MD/MPN) OR SECONDARY 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](http://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>
Bacteraemia / fungemia / viremia / parasites		
<b>SYSTEMIC SYMPTOMS OF INFECTION</b>		
Septic shock		
ARDS		

CIC:

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

SCT Date.....

yyyy mm dd

<b>Type</b>	<b>Pathogen</b> <i>Use the list of pathogens listed after this table for guidance. Use "unknown" if necessary.</i>	<b>Date</b> <i>Provide different dates for different episodes of the same complication if applicable.</i>
Multiorgan failure due to infection		
<b>ENDORGAN DISEASES</b>		
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 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**

**ADDITIONAL TREATMENT**

- Treatment given since last report
- No
- Yes: Date started: .....  
yyyy mm dd
- 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 transplant
- Unknown

## LAST DISEASE AND PATIENT STATUS

### LAST DISEASE STATUS

- Complete Remission
- Relapse
- Treatment failure / progression

### CONCEPTION

Has patient or partner become pregnant after this HSCT?

- 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	<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** .....

.....

.....

**IDENTIFICATION & SIGNATURE**

.....