

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)

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Acute Leukaemia <ul style="list-style-type: none"> <input type="checkbox"/> Myelogenous (AML) <input type="checkbox"/> Lymphoblastic (ALL) <input type="checkbox"/> Secondary Acute Leukaemia
 <small>(do not use if transformed from MDS/MPS)</small> <input type="checkbox"/> Chronic Leukaemia <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Myeloid Leukaemia (CML) <input type="checkbox"/> Chronic Lymphocytic Leukaemia <input type="checkbox"/> Lymphoma <ul style="list-style-type: none"> <input type="checkbox"/> Non Hodgkin <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Other diagnosis, specify: | <ul style="list-style-type: none"> <input type="checkbox"/> Myeloma /Plasma cell disorder <input type="checkbox"/> Solid Tumour <input type="checkbox"/> Myelodyspl. / myeloprolifer. syndrome <ul style="list-style-type: none"> <input type="checkbox"/> MDS <input type="checkbox"/> MPS <input type="checkbox"/> MD/MPS <input type="checkbox"/> Aplastic anaemia <input type="checkbox"/> Inherited disorders <ul style="list-style-type: none"> <input type="checkbox"/> Primary immune deficiencies <input type="checkbox"/> Metabolic disorders | <ul style="list-style-type: none"> <input type="checkbox"/> Hystiocytic disorders <input type="checkbox"/> Autoimmune disease <ul style="list-style-type: none"> <input type="checkbox"/> Juvenile Idiopathic Arthritis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Systemic Sclerosis <input type="checkbox"/> Haemoglobinopathy |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SPECIFICATIONS
OF THE DISEASEPLASMA 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

<i>Select one</i>	Heavy Chain <i>Select one as applicable</i>	Light Chain <i>Check light chain type</i>
<input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> IgG	<input type="checkbox"/> Kappa
<input type="checkbox"/> Common type <i>(check light and heavy chain types) →</i>	<input type="checkbox"/> IgA	<input type="checkbox"/> Lambda
<input type="checkbox"/> Light chain <i>(check type) →</i>	<input type="checkbox"/> IgD	
<input type="checkbox"/> Non secretory	<input type="checkbox"/> IgE	
<input type="checkbox"/> Plasma Cell Leukaemia	<input type="checkbox"/> IgM	
<input type="checkbox"/> Solitary plasmacytoma		
<input type="checkbox"/> Other		

STAGE AT DIAGNOSIS

Complete both staging systems

	SALMON AND DURIE		
	I	II	III
A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	ISS	
	$\beta 2$ μ glob (mg/L)	Albumin (g/L)
<input type="checkbox"/> I	<3.5	≥ 35
<input type="checkbox"/> II	<3.5	<35
	3.5 – ≤ 5.5	-----
<input type="checkbox"/> 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 Presentabn 17q Absent Presentt(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:

- CR PR MR No change
- Progression Other : 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:

- CR PR MR No change
- Progression Other : 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:**
 CR PR MR No change
 Progression Other : 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

- | | | | |
|------------------------------------------------------|------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> At diagnosis | <input type="checkbox"/> CR1 | <input type="checkbox"/> CR2 | <input type="checkbox"/> >CR2_ |
| <input type="checkbox"/> PR1 | <input type="checkbox"/> PR2 | <input type="checkbox"/> >PR2 | <input type="checkbox"/> MR |
| <input type="checkbox"/> Relapse from CR (untreated) | <input type="checkbox"/> No change | <input type="checkbox"/> Progression | <input type="checkbox"/> Unknown |

Plateau (COMPLETE ONLY IF STATUS IS MR OR PR)
 (not applicable for non secretory myeloma)
 No Yes Unknown

CLINICAL AND LABORATORY DATA

- | | |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Hb (g/dL) | <input type="checkbox"/> Not evaluated |
| Serum creatinine (µmol/L) | <input type="checkbox"/> Not evaluated |
| Serum calcium (mmol/L) | <input type="checkbox"/> Not evaluated |
| Serum albumin (g/L) | <input type="checkbox"/> Not evaluated |
| BM aspirate: % plasmacytosis | <input type="checkbox"/> Not evaluated |
| BM trephine: % plasmacytosis | <input type="checkbox"/> Not evaluated |
| Monoclonal Ig in serum (g/L) | <input type="checkbox"/> Not evaluated |
| Immunofixation of serum <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown |
| Monoclonal Ig in urine (g/24 h) | <input type="checkbox"/> Not evaluated |
| Immunofixation of urine <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown |
| Serum β2 microglobulin (mg/L) | <input type="checkbox"/> Not evaluated |

Bone structure

- Lytic lesions: Normal Minor Major Not evaluated

DISEASE STATUS AT HSCT

To be evaluated just before starting conditioning

- | | | | |
|------------------------------------------------------|------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> At diagnosis | <input type="checkbox"/> CR1 | <input type="checkbox"/> CR2 | <input type="checkbox"/> >CR2_ |
| <input type="checkbox"/> PR1 | <input type="checkbox"/> PR2 | <input type="checkbox"/> >PR2 | <input type="checkbox"/> MR |
| <input type="checkbox"/> Relapse from CR (untreated) | <input type="checkbox"/> No change | <input type="checkbox"/> Progression | <input type="checkbox"/> Unknown |

Plateau (COMPLETE ONLY IF STATUS IS MR OR PR)

(not applicable for non secretory myeloma)

- No Yes Unknown

CLINICAL AND LABORATORY DATA

- | | |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Hb (g/dL) | <input type="checkbox"/> Not evaluated |
| Serum creatinine ($\mu\text{mol/L}$) | <input type="checkbox"/> Not evaluated |
| Serum calcium (mmol/L) | <input type="checkbox"/> Not evaluated |
| Serum albumin (g/L) | <input type="checkbox"/> Not evaluated |
| BM aspirate: % plasmacytosis | <input type="checkbox"/> Not evaluated |
| BM trephine: % plasmacytosis | <input type="checkbox"/> Not evaluated |
| Monoclonal Ig in serum (g/L) | <input type="checkbox"/> Not evaluated |
| Immunofixation of serum <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown |
| Monoclonal Ig in urine (g/24 h) | <input type="checkbox"/> Not evaluated |
| Immunofixation of urine <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown |
| Serum $\beta 2$ microglobulin (mg/L) | <input type="checkbox"/> 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 6.

BEST RESPONSE TO HSCT AT 100 DAYS

- | | | | |
|------------------------------------|--------------------------------------|----------------------------------|-----------------------------|
| <input type="checkbox"/> CR1 | <input type="checkbox"/> CR2 | <input type="checkbox"/> >CR2_ | |
| <input type="checkbox"/> PR1 | <input type="checkbox"/> PR2 | <input type="checkbox"/> >PR2 | <input type="checkbox"/> MR |
| <input type="checkbox"/> No change | <input type="checkbox"/> Progression | <input type="checkbox"/> Unknown | |

If complete response: Date of CR
yyyy mm dd

Otherwise: date of evaluation :
yyyy mm dd

Plateau (COMPLETE ONLY IF STATUS IS MR OR PR)
(not applicable for non secretory myeloma)

- No Yes Unknown

CLINICAL AND LABORATORY DATA

- | | | | |
|---------------------------------|---------------------------------------------------------------------|----------------------------------------|----------------------------------|
| BM aspirate: % plasmacytosis | | <input type="checkbox"/> Not evaluated | |
| BM trephine: % plasmacytosis | | <input type="checkbox"/> Not evaluated | |
| Monoclonal Ig in serum (g/L) | | <input type="checkbox"/> Not evaluated | |
| Immunofixation of serum | <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated | <input type="checkbox"/> Unknown |
| Monoclonal Ig in urine (g/24 h) | | <input type="checkbox"/> Not evaluated | |
| Immunofixation of urine | <input type="checkbox"/> Negative <input type="checkbox"/> Positive | <input type="checkbox"/> Not evaluated | <input type="checkbox"/> Unknown |
| Serum β2 microglobulin (mg/L) | | <input type="checkbox"/> 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)**

Unique Identification Code (UIC) (if known)

Hospital Unique Patient Number

Initials: (first name(s)_surname(s))

Date of birth
yyyy mm ddDate 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

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 <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		
Multiorgan failure due to infection		

CIC:

Unique Patient Number (UPN):

SCT Date.....

yyyy mm dd

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	
Parasites	Toxoplasma gondii	Papovavirus	
	Other:	Parvovirus	
		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"/>	
TTP / HUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Renal failure requiring dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Result of blood group incompatibility	<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

COMMENTS

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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

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 <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 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)

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:	<input type="checkbox"/>		

- Unknown
- Other :

ADDITIONAL NOTES IF APPLICABLE

COMMENTS

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.....

IDENTIFICATION & SIGNATURE

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