# FOR ALL DISEASES

# ALLOGRAFT

## PATIENT

**ANTIBODIES IN THE PATIENT**
(before transplantation)

| | | | | |
|---|---|---|---|---|
| HIV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| CMV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| EBV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| HBVs | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| HBVc | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| HBVe | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| HCV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| HTLV.I | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| Toxoplasmosis | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| Other | ☐Negative | ☐Positive | Specify…………………………………… | |

**ANTIGENS** *(if applicable)*

| | | | |
|---|---|---|---|
| ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| | | | |
| ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown |
| ☐ Negative | ☐Positive | ☐Not evaluated | ☐Unknown |

**PRE-TRANSPLANT HISTORY OF DOCUMENTED INVASIVE FUNGAL INFECTION SINCE INITIAL DIAGNOSIS**

☐ No ☐ Yes ☐ Unknown

If yes:

| | | | |
|---|---|---|---|
| Candida | ☐ Yes | ☐ No | ☐ Unknown |
| Aspergillus | ☐ Yes | ☐ No | ☐ Unknown |
| Pneumocystis carinii | ☐ Yes | ☐ No | ☐ Unknown |
| Other | ☐ Yes | ☐ No | If Yes, specify ...................................... |

**PERFORMANCE SCORE**

**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)

☐ Not evaluated
☐ Unknown

Weight (kg) : ............. Height (cm) : .............

# DONOR

**Multiple donors** ☐ No
☐ Yes: Number of donors ............................ Donor number in the infusion order............................

*Make as many copies of the* DONOR *and* HISTOCOMPATIBILITY *sections as there are donors. Complete all of them and include them all in your report. For each donor Indicate in both pages their number in the infusion order and their Donor ID if known*

**Donor ID**.............................

## HLA MATCH TYPE *(DONOR RELATION WITH PATIENT)*

☐ HLA-identical sibling *(may include non-monozygotic twin)*
☐ Syngeneic *(monozygotic twin)*
☐ HLA-matched other relative
☐ HLA-mismatched relative:
Degree of allele mismatch ☐ 1 HLA antigen mismatch
☐ ≥ 2 HLA antigen mismatch *(full Haploidentical)*
☐ Unrelated donor
Donor registry/CB Bank name .......... .......... ..........
WMDA code *(up to 4 characters)* …. …. …. ….

**COMPLETE NUMBER OF MISMATCHES INSIDE EACH BOX FOR UNRELATED DONORS**

| | A | B | C | DRB1 | DQB1 | DPB1 |
|---|---|---|---|---|---|---|
| Antigenic *(HLA code is 2 digits)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allelic *(HLA code is 4 digits)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*0=match; 1=one mismatch;* 2=2 *mismatches; N/E=not evaluated*

## BLOOD GROUP, DATE OF BIRTH AND SEX OF DONOR

ABO group : ☐ A ☐ B ☐ AB ☐ O

Date of birth : ...... ........ ........ ........ - ........ ........ - ........ ........
yyyy mm dd

Sex : ☐ Male ☐ Female

## SEROLOGIC STATUS OF THE DONOR *(before HSCT*

| | | | | | ANTIGENS *(if applicable)* |
|---|---|---|---|---|---|
| HIV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | ☐Negative ☐Positive ☐Not evaluated ☐Unknown |
| CMV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| EBV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| HBVs | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | ☐Negative ☐Positive ☐Not evaluated ☐Unknown |
| HBVc | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| HBVe | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | ☐Negative ☐Positive ☐Not evaluated ☐Unknown |
| HCV | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | ☐Negative ☐Positive ☐Not evaluated ☐Unknown |
| HTLV.I | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| Syphilis | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| Toxoplasmosis | ☐Negative | ☐Positive | ☐Not evaluated | ☐Unknown | |
| Other | ☐Negative | ☐Positive | Specify……………………………… | | |

CIC: Unique Patient Number (UPN): ................................ SCT Date........ ........ ........ ........ - ........ ........ - ........ ........
yyyy mm dd

**GROWTH FACTORSADMINISTERED TO THE DONOR**
*(cytokines)*

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

## HISTOCOMPATIBILITY

**PLEASE SEND COPIES OF THE ORIGINAL HLA TYPING FORM(S).**
**If you do so, you do not need to fill in this HISTOCOMPATIBILITY section**

**LOCATION**

Laboratory / Hospital .................................................................................... Unit ......................................................................

Contact number *(telephone/fax)* .................................................................................. ......................................................................

Technique Used ................................................................................................................................ ..........................................................................

**DONOR HLA PHENOTYPE**

IF MULTIPLE DONORS:

Donor number in the infusion order.............................

**Donor ID**............................ *(or use date of birth to identify donor in this section)*

A revised listing of recognised HLA specificities is issued by the WHO nomenclature and is available at: http://hla.alleles.org/nomenclature/nomenclature_2009.html

| **HLA Type** | **A** | | **B** | | **C** | |
|---|---|---|---|---|---|---|
| Antigenic *(Serology)* | | | | | | |
| Allelic *(DNA /molecular)* | | | | | | |
| **HLA Type** | **DRB1** | | **DQB1** | | **DPB1** | |
| Antigenic *(Serology)* | | | | | | |
| Allelic *(DNA /molecular)* | | | | | | |

**PATIENT HLA PHENOTYPE:**

| **HLA Type** | **A** | | **B** | | **C** | |
|---|---|---|---|---|---|---|
| Antigenic *(Serology)* | | | | | | |
| Allelic *(DNA /molecular)* | | | | | | |
| **HLA Type** | **DRB1** | | **DQB1** | | **DPB1** | |
| Antigenic *(Serology)* | | | | | | |
| Allelic *(DNA /molecular)* | | | | | | |

# TRANSPLANTATION

**SOURCE OF STEM CELLS**
*Check all that apply:*

☐ Bone marrow ☐ Peripheral blood
☐ Cord blood *(Please complete Cord Blood Form)*
☐ Other : ..........................................................................................................

**Chronological number of HSCT for this patient** ...........

If > 1, date of previous HSCT: ...... ....... ....... ........ - ........ ........ - ....... ........
yyyy mm dd

Type of previous HSCT ☐ Allo ☐ Auto
Donor the same as for previous HSCT? ☐ No ☐ Yes ☐ Previous HSCT(s) autologous

**HSCT part of a multiple sequential graft protocol**

☐ No
☐ Yes: Type of multiple graft protocol .............................................
Graft number in the protocol _____ out of _____ total number of HSCTs in the program
☐ Unknown

# GRAFT MANIPULATION

**GRAFT MANIPULATION *EX-VIVO* (INCLUDING T-CELL DEPLETION)**

☐ No ☐ Yes

**NEGATIVE SELECTION**
☐ No
☐ Yes:
☐ T-cell depletion by MoAB *(do not enter "Campath in bag" here)*
☐ B-cell depletion by MoAB
☐ NK cell depletion by MoAB
☐ Elutriation
☐ Other : ..........................................................................................................................
☐ Unknown

**POSITIVE SELECTION**
☐ No
☐ Yes: Monoclonal antibodies: ☐ No
☐ Yes: ☐ CD 34+ ☐ Other: ..............................
☐ Unknown
Other: ..........................................
☐ Unknown

**EXPANSION**
☐ No ☐ Yes ☐ Unknown

**GENE MANIPULATION**
*(gene transfer/transduction)*
☐ No ☐ Yes ☐ Unknown

# PREPARATIVE TREATMENT *(conditioning)* AND INFUSION

## PREPARATIVE (CONDITIONING) REGIMEN GIVEN

☐ No

☐ Yes: Was regimen intended to be myeloablative

☐ No:

| Reason not myeloablative | Main reason *(tick only one)* | Additional reason *(tick as many as necessary)* |
|---|---|---|
| ☐ Age of recipient | ☐ | ☐ |
| ☐ Comorbid conditions | ☐ | ☐ |
| ☐ Prior HSCT | ☐ | ☐ |
| ☐ Protocol driven | ☐ | ☐ |
| ☐ Other, specify .......... ...... | ☐ | ☐ |

☐ Yes

☐ Unknown

**Drugs** ☐ No ☐ Yes ☐ Unknown

*(include any active agent be it chemo, monoclonal antibody, policlonal antibody, serotherapy, etc.)*

*NOTE: ONLY AGENTS GIVEN* ***BEFORE*** *THE DATE OF THE 1ST CELL INFUSION (DAY 0) SHOULD BE LISTED HERE*

| NAME | PRESCRIBED CUMULATIVE DOSE AS PER PROTOCOL (DAILY DOSE BY NUMBER OF DAYS) | UNITS IF NOT RADIOLABELLED MOAB * | UNITS IF RADIOLABELLED MOAB |
|---|---|---|---|
| *(1)*............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(2)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(3)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(4)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(5)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(6)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |
| *(7)* ............................................................ ........................ | .................... | ☐ mg ☐ mg/m² ☐ mg/Kg | O mCi O mBq |
| Radiolabelled *(MoAB only)* ☐ No ☐ Yes ☐ Unknown | | | |

** If the unit you need is not listed, please write it on the side.*

ADDITIONAL DRUG INFORMATION

For Busulphan: Route of administration: ☐ Oral ☐ IV ☐ Both

For ALG, ATG *(ALS, ATS)*: Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify.... ........ .........

**TBI** ☐ No ☐ Yes ☐ Unknown

*(If yes, complete TBI Form)*

Total dose (Gy) : ....... ........ - ........ Number of fractions ........... ........ over ........... ........ radiation days

**TLI / TNI / TAI** ☐ No ☐ Yes: Total dose (Gy) : ....... ........ - ........ ☐ Unknown

**Local radiotherapy** ☐ No ☐ Yes ☐ Unknown

CIC: Unique Patient Number (UPN): ................................. SCT Date....... ....... ....... ....... - ....... ....... - ....... .......
yyyy mm dd

**CELLS INFUSED**

| Total number of cells actually infused | Bone Marrow | Peripheral Blood | Cord Blood |
|---|---|---|---|
| Nucleated cells (/kg*) | ...... ........ - ...... ....... ........ x $10^8$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^8$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^8$ ☐ Not evaluated ☐ unknown |
| CD 34+ (cells/kg*) | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown |
| T-cells (cells/kg*) *(if known)* | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown | ...... ........ - ...... ....... ........ x $10^6$ ☐ Not evaluated ☐ unknown |

*(* kg of recipient body weight)*

# TREATMENT DURING THE IMMEDIATE POST-TRANSPLANT PERIOD

**GROWTH FACTORS** *(CYTOKINES)*
*(excluding growth factors administered for engraftment failure)*

☐ No

☐ Yes, specify ........................................................ Date started : ....... .. ....... ....... - ..... ....... - ....... .......
yyyy mm dd

☐ Unknown

**CELLULAR THERAPY**

☐ No
☐ Yes: Date of first infusion: ........... ........... ...........
*(can be the same as HSCT date)* *yyyy mm dd*
☐ Unknown

IF YES:

☐ Donor lymphocyte infusion (DLI) *Please, fill in relevant information in the* DLI Med-B *insert*

☐ Mesenchymal cells *Please, fill in relevant information in the* Cell Therapy Med-A

☐ 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
☐ 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)*

### GvHD PREVENTION IN THE RECIPIENT (THERAPEUTIC IMMUNOSUPPRESSION)

☐ No

☐ Yes: **Drugs**

ONLY AGENTS STARTED ***AFTER*** THE DATE OF THE 1ST CELL INFUSION (DAY 0) SHOULD BE TICKED HERE

☐ Cyclosporin ☐ Methotrexate ☐ ATG/ALG

☐ Corticosteroids ☐ Mycophenolate ☐ Tacrolimus

☐ Monoclonal antibodies, specify ..................................................... *(may include 'Campath in bag')*

☐ Extra-corporeal photopheresis (ECP)

☐ Other : ........................................................................................................................

☐ Unknown

## ENGRAFTMENT

### GRAFT PERFORMANCE

☐ Engraftment

**Haemopoietic reconstitution** *(first of 3 consecutive days)*

Neutrophils > 0.5 x $10^9$/l reached? ENGNEUR
☐ Yes: Date Neutrophils > 0.5 x $10^9$/l ....... . ........ ............... - ........ ........ - ........ ........ DATRCGR2
*yyyy mm dd*
☐ No
☐ Never below this level

Platelets > 20 x $10^9$/l reached?
☐ Yes: Date Platelets > 20 x $10^9$/l ....... ........ ................ - ........ ........ - ........ ........
*yyyy mm dd*
☐ No
☐ Never below this level

Platelets > 50 x $10^9$/l reached? VPLAT50A
☐ Yes: Date Platelets > 50 x $10^9$/l ....... ........ ................ - ........ ........ - ........ ........ DPLAT50
*yyyy mm dd*
☐ No
☐ Never below this level

Date last platelet transfusion :........ . .............. - ........ ........ - ........ ........ ........ ☐ Not applicable: not transfused
*yyyy mm dd*

☐ No engraftment: Date last assessment ....... .. ............. - ........ ........ - ........ ........ ........ .
*yyyy mm dd*

☐ Lost graft ; date of graft failure ........ ....... ........ - ........ ........ - ........ ........ ........ ..
*yyyy mm dd*

### HAEMOPOIETIC CHIMAERISM

☐ Not performed ☐ Full (donor 95 %) ☐ Mixed ☐ Autologous reconstitution (recipient 95 %) ☐ Aplasia

**Method used**

☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO Group

Date : ........ ........ ....... ........- ........ ........ - ........ ........ .
*yyyy mm dd*

### TREATMENT FOR FAILURE
*(If engraftment failure)*

- ☐ No
- ☐ Growth factors
- ☐ Subsequent transplant *(please complete a new transplant form)*:

  Date : ........ ........ ........ ........ - ........ ........ - ........ ........ ☐ AUTOgraft *(must have prior conditioning)*
  *yyyy mm dd* ☐ ALLOgraft
- ☐ Autologous PBSC re-infusion *(no preparative treatment or conditioning)*
- ☐ Autologous BM re-infusion *(no preparative treatment or conditioning)*
- ☐ Other : ..........................................................................................................................................................

## ACUTE GvHD

### aGvHD MANIFESTATION

☐ Present:

**Maximum grade**
☐ grade I ☐ grade II ☐ grade III ☐ grade IV

Date of onset : ........ ........ ........ ........- ........ ........ - ........ ........
*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 |

☐ Absent
☐ Not evaluated
☐ unknown

### aGvHD RESOLUTION

☐ No ☐ Yes: Date of resolution: ........ ........ ........ ........- ........ ........ - ........ ........
*yyyy mm dd*

**Treatment**

☐ No
☐ Yes ☐ Corticosteroids ☐ MoAB: ...........................................................................
☐ ATG/ALG ☐ Other : ...........................................................................

# COMPLICATIONS WITHIN THE FIRST 100 DAYS.

*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<br>*Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.* | Date<br>*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 | | |
| | | |
| | | |

| Type | Pathogen<br>*Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.* | Date<br>*Provide different dates for different episodes of the same complication if applicable.* |
|---|---|---|
| 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 |
| | | | EBV |
| | Haemophilus influenzae | | CMV |
| | Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)* | | HHV-6 |
| | | | RSV |
| | Legionella sp | | Other respiratory virus *(influenza, parainfluenza, rhinovirus)* |
| | Mycobacteria sp | | |
| | Other: ...................... | | Adenovirus |
| Fungi | | | HBV |
| | Candida sp | | HCV |
| | Aspergillus sp | | HIV |
| | Pneumocystis carinii | | Papovavirus |
| | Other: ...................... | | Parvovirus |
| Parasites | | | Other: ...................... |
| | Toxoplasma gondii | | |
| | 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 | ☐ | ☐ | ☐ | |
| Transplant-associated microangiopathy | ☐ | ☐ | ☐ | |
| Renal failure requiring dialysis | ☐ | ☐ | ☐ | |
| Haemolytic anaemia due to blood group | ☐ | ☐ | ☐ | |
| Aseptic bone necrosis | ☐ | ☐ | ☐ | |
| Other: ..........................................…… | ☐ | | | |
| | | | | *yyyy mm dd* |

# STATUS AT 100 DAYS

**DATE OF LAST CONTACT:** . ................ ................ - ........ ........ - ................
*yyyy mm dd*

**RELAPSE OR PROGRESSION**

☐ No

☐ Yes; date diagnosed: ................ ................ - ........ ........ - ................
*yyyy mm dd*

*FOR LEUKAEMIAS ONLY, IF RELAPSE OR PROGRESSION IS YES, FILL IN METHOD DETAILS:*

| Method of detection | Date of the assessment | Site |
|---|---|---|
| Cinical/haematological relapse or progression VRELLEUK | ☐ No: Date assessed ........... - ........... - ........... *yyyy mm dd* | DHEMREL |
| | ☐ Yes: Date first seen ........... - ........... - ........... *yyyy mm dd* | ☐ marrow – blood ☐ extramedullary |
| | ☐ Not evaluated | VRELLEU2 |
| Cytogenetic relapse or progression | ☐ No: Date assessed ........... - ........... - ........... *yyyy mm dd* | |
| ☐ Not evaluated | ☐ Yes: Date first seen ........... - ........... - ........... *yyyy mm dd* | ☐ marrow – blood ☐ extramedullary |
| | ☐ Not evaluated | |
| Molecular relapse or progression | ☐ No: Date assessed ........... - ........... - ........... *yyyy mm dd* | DMOLREL |
| VRELLEU5 ☐ Not evaluated | ☐ Yes: Date first seen ........... - ........... - ........... *yyyy mm dd* | ☐ marrow – blood ☐ extramedullary |
| | ☐ Not evaluated | VRELLEU6 |

☐ Continuous progression since transplant

☐ Unknown

**LAST DISEASE STATUS** *(record the most recent status and date for each method, depending on the disease)*

| Method | Disease detected | | |
|---|---|---|---|
| Clinical/haematological | ☐ No ☐ Yes | | |
| | Last date evaluated ........... - ........... - ........... *yyyy mm dd* | | ☐ Not evaluated |
| *FILL IN ONLY FOR ACUTE AND CHRONIC LEUKAEMIAS* | | | |
| Cytogenetic/FISH | ☐ No ☐ Yes: Considered disease relapse/progression | ☐ No ☐ Yes | |
| | Last date assessed ........... - ........... - ........... *yyyy mm dd* | | ☐ Not evaluated |
| Molecular | ☐ No ☐ Yes: Considered disease relapse/progression | ☐ No ☐ Yes | |
| | Last date assessed ........... - ........... - ........... *yyyy mm dd* | | ☐ Not evaluated |

**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
- ☐ Transplantation 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 : ..........................................................................................................

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# ADDITIONAL NOTES IF APPLICABLE

**COMMENTS** ..........................................................................................................

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# IDENTIFICATION & SIGNATURE

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FOR ALL DISEASES

# ALLOGRAFT APPENDIX

**PATIENT ETHNIC OR RACIAL ORIGIN**

*Only compulsory for USA centres or HSCT performed with USA donors. USA Federal socio-political standards used. Contact the CIBMTR if clarification is needed.*

**Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race** *(check all that apply)*

☐ White ☐ Black ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

**COMORBID CONDITIONS**

*Compulsory for CIBMTR Research centres / Optional for other centres wishing to include these items in their own studies*

Were there any ***clinically significant*** co-existing disease or organ impairment at time of patient assessment prior to preparative *(conditioning)* regimen?

☐ No

☐ Yes:

| Comorbidity | | Definitions | No | Yes | Not evaluated |
|---|---|---|---|---|---|
| Solid tumor, previously present | | Treated at any time point in the patient's past history, excluding nonmelanoma skin cancer | ☐ | ☐ | ☐ |
| Inflammatory bowel disease | | Crohn's disease or ulcerative colitis | ☐ | ☐ | ☐ |
| Rheumatologic | | SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica | ☐ | ☐ | ☐ |
| Infection | | Requiring continuation of antimicrobial treatment after day 0 | ☐ | ☐ | ☐ |
| Diabetes | | Requiring treatment with insulin or oral hypoglycemics but not diet alone | ☐ | ☐ | ☐ |
| Renal: | moderate/severe | Serum creatinine > 2 mg/dL or >177 µmol/L, on dialysis, or prior renal transplantation | ☐ | ☐ | ☐ |
| Hepatic: | mild | Chronic hepatitis, bilirubin > ULN to 1.5 × ULN, or AST/ALT > ULN to 2.5 × ULN | ☐ | ☐ | ☐ |
| | moderate/severe | Liver cirrhosis, bilirubin > 1.5 × ULN, or AST/ALT > 2.5 × ULN | ☐ | ☐ | ☐ |
| Arrhythmia | | Atrial fibrillation or fl utter, sick sinus syndrome, or ventricular arrhythmias | ☐ | ☐ | ☐ |
| Cardiac | | Coronary artery disease, congestive heart failure, myocardial infarction, or EF ≤ 50% | ☐ | ☐ | ☐ |
| Cerebrovascular disease | | Transient ischemic attack or cerebrovascular accident | ☐ | ☐ | ☐ |
| Heart valve disease | | Except mitral valve prolapse | ☐ | ☐ | ☐ |
| Pulmonary: | moderate | DLco and/or FEV1 66-80% or dyspnea on slight activity | ☐ | ☐ | ☐ |
| | severe | DLco and/or FEV1 ≤ 65% or dyspnea at rest or requiring oxygen | ☐ | ☐ | ☐ |
| Obesity | | Patients with a body mass index > 35 kg/m2 | ☐ | ☐ | ☐ |
| Peptic ulcer | | Requiring treatment | ☐ | ☐ | ☐ |
| Psychiatric disturbance | | Depression or anxiety requiring psychiatric consult or treatment | ☐ | ☐ | ☐ |
| Other Specify........................................................................................................................ | | | ☐ | ☐ | ☐ |