



EBMT Centre Identification Code (CIC): \_\_\_\_\_  
Hospital Unique Patient Number (UPN): \_\_\_\_\_  
Patient Number in EBMT Registry: \_\_\_\_\_

Treatment Type  HCT  CT  IST  Other  
Treatment Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)

## HAEMOGLOBINOPATHIES

### DISEASE

**Note: complete this form only if this diagnosis was the indication for the HCT/GT or if it was specifically requested. Consult the manual for further information.**

Date of diagnosis/date of first event: \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)

#### Classification:

- Thalassaemia; **Type:**   $\beta 0 / \beta 0$   
  $\beta 0 / \beta +$   
  $\beta 0 / \beta E$   
  $\beta + / \beta E$   
  $\beta + / \beta +$   
 Other; specify: \_\_\_\_\_

- Sickle cell disease; **Type:**  SS  
 SC  
 SB+  
 SB0  
 Other; specify: \_\_\_\_\_

- Other haemoglobinopathy; specify: \_\_\_\_\_