



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

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

AUTOLOGOUS HAEMATOPOIETIC CELL TRANSPLANTATION (HCT) Day 0

Date of this HCT: ____/____/____ (YYYY/MM/DD)
(or planned date of HCT if patient died before treatment)

Centre where this HCT took place (CIC): _____

Patient UPN for this treatment: _____

Team or unit where treatment took place (select all that apply):

- Adults Pediatrics Haematology Oncology Allograft Autograft Other; specify: _____

Unit number: _____ Not applicable

Indication diagnosis for this HCT: _____
(make sure the indication diagnosis has been registered first, using the relevant diagnosis form)

Extended dataset

Only for Chronic Myeloid Leukaemia (CML) patients

- Reason for HCT (select as many reasons as applicable):**
- | | |
|---|---|
| <input type="checkbox"/> Accelerated phase | <input type="checkbox"/> Clonal evolution |
| <input type="checkbox"/> Blast crisis | <input type="checkbox"/> Poor risk patient or high risk CML |
| <input type="checkbox"/> TKI intolerance | <input type="checkbox"/> ABL mutation |
| <input type="checkbox"/> Imatinib resistance | <input type="checkbox"/> Standard indication at diagnosis |
| <input type="checkbox"/> Dasatinib resistance | <input type="checkbox"/> No engraftment/graft loss |
| <input type="checkbox"/> Nilotinib resistance | <input type="checkbox"/> Clinical study |
| <input type="checkbox"/> Asciminib resistance | <input type="checkbox"/> Other, specify : _____ |
| <input type="checkbox"/> Ponatinib resistance | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Bosutinib resistance | |

Chronological number of this treatment: _____
(all types of treatments for this patient, e.g. HCT, CT, GT, IST)

Chronological number of this HCT: _____
(all HCTs this patient received in the past)

Chronological number of this autologous HCT: _____
(all autologous HCTs this patient received in the past)



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Complete this section only if the chronological number of the treatment is >1 for this patient.

if > 1:

Reason for this HCT:

- Indication diagnosis
- Relapse/progression after previous treatment (HCT/CT/GT/IST)
- Complication after previous treatment (HCT/CT/GT/IST)
- Primary graft failure
- Secondary graft failure
- Secondary malignancy
- Other; specify: _____

Date of the last treatment before this one: ____/____/____ (YYYY/MM/DD)

Type of the last treatment before this one:

- Autologous HCT
- Allogeneic HCT
- Cellular therapy (CT)
- Immunosuppressive treatment (IST)
- Gene therapy (GT)

Was the last treatment performed at another institution?

- No
- Yes: CIC (if known): _____

Name of institution: _____

City: _____

Submit the relevant follow-up form for the previous HCT/CT/GT/IST using the follow up assessment date before this HCT. It is required to capture relapse data and other events between transplants/cellular therapies.



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GRAFT INFORMATION

Is this HCT part of a (planned) multiple (sequential) graft program/protocol?

- No
 Yes: **Chronological number of this HCT as part of multiple (sequential) graft program/protocol for this patient:** _____

Source of stem cells:

(check all that apply)

- Bone marrow
 Peripheral blood
 Cord blood
 Other; specify: _____

Graft manipulation ex-vivo:

(other than for gene therapy, RBC removal or volume reduction)

- No
 Yes: CD34+ enrichment
 Other manipulation; specify: _____

Was the graft cryopreserved prior to infusion?

- No
 Yes
 Unknown



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MOBILISATION
Autoimmune Diseases only

Mobilisation drugs given?

No

Yes; Start date of mobilisation: ____/____/____ (YYYY/MM/DD)

Cyclophosphamide: No Yes Dose (g/m²): _____

Corticosteroids: No Yes Daily dose (mg/kg): _____

G-CSF: No Yes

Plerixafor: No Yes

Other; specify*: _____

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names

Extended dataset

MOBILISATION
All diagnoses except Autoimmune Diseases

Number of mobilisations: _____ Unknown

	Start date of mobilisation (YYYY/MM/DD)	Drugs given at mobilisation (select from the EBMT Drugs list)
Mobilisation 1	____/____/____ <input type="checkbox"/> Unknown	
Mobilisation 2	____/____/____ <input type="checkbox"/> Unknown	
Mobilisation 3	____/____/____ <input type="checkbox"/> Unknown	

Infused cells counts per product

Source of cells for this product: Bone marrow Peripheral blood Cord blood Other, specify _____

Cell counts for this cell product:

*Cell type	*Counts	*Units
Nucleated cells (/kg)	_____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	<input type="checkbox"/> x10 ⁶ /kg <input type="checkbox"/> x10 ⁷ /kg <input type="checkbox"/> x10 ⁸ /kg
CD34+ cells (/kg)	_____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	<input type="checkbox"/> x10 ⁵ /kg <input type="checkbox"/> x10 ⁶ /kg
CD3+ cells (/kg)	_____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	<input type="checkbox"/> x10 ⁵ /kg <input type="checkbox"/> x10 ⁶ /kg <input type="checkbox"/> x10 ⁷ /kg <input type="checkbox"/> x10 ⁸ /kg

If products from different sources were infused, copy and fill-in this table as many times as necessary per each source of cells.



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PREPARATIVE REGIMEN
(All Diagnoses)

Preparative (conditioning) regimen given? *(any active agent, including chemotherapy, monoclonal antibody, polyclonal antibody, serotherapy, etc.)*

- No *(usually paediatric inherited disorders only)*
- Yes (provide details on pages 4-5)

Autoimmune diseases only:

Serotherapy given?

- No
- Yes : Alemtuzumab
 - Rituximab
 - ATG
 - Other; specify: _____



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PREPARATIVE REGIMEN continued**Specification and dose of the preparative regimen:***(Report the total prescribed cumulative dose as per protocol. Multiply daily dose by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg.)*

Chemotherapy	Dose	Unit
<input type="checkbox"/> Alemtuzumab	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-Thymocyte Globulin Anti-Lymphocyte Globulin Product name: _____ Origin: <input type="checkbox"/> Rabbit <input type="checkbox"/> Horse <input type="checkbox"/> Other; specify: _____	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Bendamustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Bleomycin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Busulfan Route of administration: <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Both Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carboplatin Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carmustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cisplatin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Clofarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
Corticosteroids:		
<input type="checkbox"/> Beclometasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Budesonide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Dexamethasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Methylprednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Prednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cyclophosphamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg



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<input type="checkbox"/> Cytarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Daunorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Doxorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Epirubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Etoposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Fludarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Gemtuzumab ozogamicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Ibritumomab tiuxetan	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Idarubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Ifosfamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Imatinib	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Lomustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Melphalan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Mitoxantrone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Paclitaxel	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-CD20 antibodies	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Teniposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Thiotepa	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Tositumomab	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Treosulfan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Other; specify*: _____	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg <input type="checkbox"/> mCi <input type="checkbox"/> MBq

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names**Total body irradiation (TBI):** No Yes; Total prescribed radiation dose as per protocol: _____ Gy

Number of fractions: _____

Number of radiation days: _____

END OF THE AUTO-HCT DAY 0 REPORT**proceed to form DISEASE STATUS AT HCT/CT/GT/IST**