

## IMMUNOSUPPRESSIVE TREATMENT (IST) Day 0 (For Bone Marrow Failure only)

*This form should be filled in for each individual immunosuppressive treatment episode.*

Date this IST episode started: \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)

Centre where this IST took place (CIC): \_\_\_\_\_

Patient UPN for this treatment: \_\_\_\_\_

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

Adults     Pediatrics     Hematology     Oncology     Allograft     Autograft     Other; specify: \_\_\_\_\_

Indication diagnosis for this IST episode: \_\_\_\_\_

*(make sure you registered indication diagnosis using relevant diagnosis form first)*

Chronological number of this treatment: \_\_\_\_\_

*(all types of treatments for this patient, e.g. HCT, CT, GT, IST)*

Reason for this IST episode:

- First line treatment
- Failure of first line therapy
- Relapse
- PR to previous treatment
- Other; specify: \_\_\_\_\_
- Unknown

Chronological number of this IST episode: \_\_\_\_\_

## TRANSFUSIONS

*Complete this section only if this is the first IST episode ever for this patient:*

RBC transfusions given before the 1<sup>st</sup> IST episode:     No     Yes     Unknown

- |      |  |                 |                                  |
|------|--|-----------------|----------------------------------|
| RBC: | <input type="checkbox"/> < 20 units    | RBC irradiated: | <input type="checkbox"/> No      |
|      | <input type="checkbox"/> 20 - 50 units |                 | <input type="checkbox"/> Yes     |
|      | <input type="checkbox"/> > 50 units    |                 | <input type="checkbox"/> Unknown |
|      | <input type="checkbox"/> Unknown       |                 |                                  |

Platelet transfusions given before the 1<sup>st</sup> IST episode:     No     Yes     Unknown

- |            |  |                       |                                  |
|------------|--|-----------------------|----------------------------------|
| Platelets: | <input type="checkbox"/> < 20 units    | Platelets irradiated: | <input type="checkbox"/> No      |
|            | <input type="checkbox"/> 20 - 50 units |                       | <input type="checkbox"/> Yes     |
|            | <input type="checkbox"/> > 50 units    |                       | <input type="checkbox"/> Unknown |
|            | <input type="checkbox"/> Unknown       |                       |                                  |



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

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

**IMMUNOSUPPRESSION**

**Drugs used for immunosuppression during this IST episode (check at least one):**

Drug given	Start Date (YYYY/MM/DD)	Stop Date (YYYY/MM/DD)
<input type="checkbox"/> Alemtuzumab	____/____/____	____/____/____
<input type="checkbox"/> Anti-CD20 antibodies	____/____/____	____/____/____
<input type="checkbox"/> Anti-Thymocyte Globulin (ATG) Product name: _____ Origin: <input type="checkbox"/> Rabbit <input type="checkbox"/> Horse <input type="checkbox"/> Other; specify: _____	____/____/____	____/____/____
<input type="checkbox"/> Beclometasone	____/____/____	____/____/____
<input type="checkbox"/> Budesonide (for systemic immunosuppression)	____/____/____	____/____/____
<input type="checkbox"/> Cyclophosphamide	____/____/____	____/____/____
<input type="checkbox"/> Cyclosporine	____/____/____	____/____/____
<input type="checkbox"/> Danazol	____/____/____	____/____/____
<input type="checkbox"/> Dexamethasone	____/____/____	____/____/____
<input type="checkbox"/> Etiocholanolone	____/____/____	____/____/____
<input type="checkbox"/> Filgrastim	____/____/____	____/____/____
<input type="checkbox"/> Flouxymesterone	____/____/____	____/____/____
<input type="checkbox"/> Lenograstim	____/____/____	____/____/____
<input type="checkbox"/> Methylprednisolone	____/____/____	____/____/____
<input type="checkbox"/> Mycophenolate mofetil	____/____/____	____/____/____
<input type="checkbox"/> Nandrolone	____/____/____	____/____/____
<input type="checkbox"/> Norethandrolone	____/____/____	____/____/____
<input type="checkbox"/> Oxandrolone	____/____/____	____/____/____
<input type="checkbox"/> Oxymetholone	____/____/____	____/____/____
<input type="checkbox"/> Pegfilgrastim	____/____/____	____/____/____
<input type="checkbox"/> Prednisolone	____/____/____	____/____/____
<input type="checkbox"/> Testosterone	____/____/____	____/____/____
<input type="checkbox"/> Other; specify*: _____	____/____/____	____/____/____

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

***proceed to form DISEASE STATUS AT HCT/CT/GT/IST***

### IMMUNOSUPPRESSION

**Drugs used for immunosuppression during this IST episode (check at least one):**

Drug given	<i>Extended dataset</i> Dose of drugs	Units of measurement
<input type="checkbox"/> Alemtuzumab	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-CD20 antibodies	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-Thymocyte Globulin (ATG) Product name: _____ Origin: <input type="checkbox"/> Rabbit <input type="checkbox"/> Horse <input type="checkbox"/> Other; specify: _____	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Beclometasone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Budesonide (for systemic immunosuppression)	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cyclophosphamide	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cyclosporine	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Danazol	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Dexamethasone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Etiocholanolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Filgrastim	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Fluoxymersterone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Lenograstim	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Methylprednisolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Mycophenolate mofetil	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Nandrolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Norethandrolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Oxandrolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Oxymetholone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Pegfilgrastim	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Prednisolone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Testosterone	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg
<input type="checkbox"/> Other; specify*: _____	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> g <input type="checkbox"/> g/m <sup>2</sup> <input type="checkbox"/> g/kg <input type="checkbox"/> mg <input type="checkbox"/> mg/m <sup>2</sup> <input type="checkbox"/> mg/kg

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**proceed to form DISEASE STATUS AT HCT/CT/IGT/IST**