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

Treatment Type ☐ HCT

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

# ALLOGENEIC 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:** _____

**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):

☐ Accelerated phase
☐ Blast crisis
☐ TKI intolerance
☐ Imatinib resistance
☐ Dasatinib resistance
☐ Nilotinib resistance
☐ Asciminib resistance
☐ Ponatinib resistance
☐ Bosutinib resistance
☐ Clonal evolution
☐ Poor risk patient or high risk CML
☐ ABL mutation
☐ Standard indication at diagnosis
☐ No engraftment/graft loss
☐ Clinical study
☐ Other, specify : _____
☐ Unknown

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

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

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

# ALLOGENEIC HAEMATOPOIETIC CELL TRANSPLANTATION (HCT)
## Day 0

*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.*

## DONOR & GRAFT

**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:** _____

**If this is the first allogeneic HCT for this patient, complete the patient HLA section in the database.**

**Multiple donors** *(including multiple CB units)***:**

☐ No

☐ Yes: **Number of donors**: _____

## DONOR INFORMATION
## --- Donor __ (number)---

*Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.*

**Did the donor consent to having their data in the EBMT registry?**

☐ No (complete only fields marked with '*' on pages 4-8)

☐ Yes

**Date of birth:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

*(year of birth is a mandatory field)*

***Age at time of donation:** _____ **years**
*(optional)*

*(Skip if the source of stem cells is cord blood)*

***Age in months:** ____
*(optional, if the donor was younger than 2 years)*

***Sex** *(at birth)*:

☐ Male

☐ Female

**Donor Identification:**

Donor ID given by the treating centre *(mandatory)*: _____

Global registration identifier for donors (GRID): _____

ION code of the Donor Registry or Cord Blood Bank *(mandatory)*: _____

EuroCord code for the Cord Blood Bank *(if applicable)*: _____

Name of Donor Registry or Cord Blood Bank: _____

Donor ID given by the Donor Registry or Cord Blood Bank: _____

Patient ID given by the Donor Registry or Cord Blood Bank: _____

***Donor blood group:**

☐ A
☐ B
☐ AB
☐ O

***Donor rhesus factor:**

☐ Negative
☐ Positive

***Donor EBV status:**

☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

***Donor CMV status:**

☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

***Is donor heterozygous?** *(Sickle cell disease only)*

☐ No
☐ Yes

***Is donor a carrier for X-linked disease?** *(Inborn Errors only)*

☐ No
☐ Yes

***Did this donor provide more than one stem cell product:**

☐ No
☐ Yes: ***Number of different stem cell products from this donor**: _____

*(If 2 products e.g. BM and PM, complete 'Donor 1 - Product Number 1* ***and*** *2' on page 5)*

## DONOR INFORMATION
### --- Donor __(number) continued ---
*Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.*

### *Donor __(number) - Product Number 1

*If more than one stem cell product , this is the first product collected from this donor.*

***Source of stem cells:** ☐ Bone Marrow ☐ Peripheral Blood ☐ Cord Blood ☐ Other; specify: _____
*(select only one)*

***Graft manipulation *ex-vivo* including T-cell depletion:**
*(other than for RBC removal or volume reduction)*

☐ No

☐ *Yes:
- ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ CD34+ enrichment
- ☐ Genetic manipulation
- ☐ Other; specify: _____

*Extended dataset*

***Infused cell counts for this product**

| *Cell type | *Counts | *Units |
|---|---|---|
| Nucleated cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^6$/kg ☐ x10$^7$/kg ☐ x10$^8$/kg |
| CD34+ cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^5$/kg ☐ x10$^6$/kg |
| CD3+ cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^5$/kg ☐ x10$^6$/kg ☐ x10$^7$/kg ☐ x10$^8$/kg |

***Was the graft cryopreserved prior to infusion?**
- ☐ No
- ☐ Yes; ***Date of cryopreservation:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* ☐ Unknown
- ☐ Unknown

*Extended dataset*

### Cord blood

***Cell infusion for this product**

***Route:**
- ☐ Intravenous (IV)
- ☐ Intrabone/intramedullary
- ☐ Other; specify: _____
- ☐ Unknown

***Method:**
- ☐ DMSO
- ☐ Wash (Rubinstein/New York)
- ☐ Other; specify: _____
- ☐ Unknown

***Cell viability tests performed at HCT centre:** ☐ No ☐ Yes;

***Tests performed after thawing of an aliquot on:**
- ☐ Contiguous segment
- ☐ Reference bag
- ☐ Unknown

***Method used:**
- ☐ 7-AAD
- ☐ Tryptan blue
- ☐ Acridine orange-ethidium bromide
- ☐ Acridine orange-ethidium iodide
- ☐ Other; specify _____
- ☐ Unknown

***Viability of all cells:** _____ % ☐ Unknown

***Viability of CD34+ cells:** _____ % ☐ Unknown

## DONOR INFORMATION
### --- Donor __(number) continued ---
*Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.*

### *Donor __(number) - Product Number 2

*If more than one stem cell product , this is the first product collected from this donor.*

***Source of stem cells:** ☐ Bone Marrow ☐ Peripheral Blood ☐ Cord Blood ☐ Other; specify: _____
*(select only one)*

***Graft manipulation *ex-vivo* including T-cell depletion:**
*(other than for RBC removal or volume reduction)*

☐ No

☐ *Yes:
- ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ CD34+ enrichment
- ☐ Genetic manipulation
- ☐ Other; specify: _____

*Extended dataset*

***Infused cell counts for this product**

| *Cell type | *Counts | *Units |
|---|---|---|
| Nucleated cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^6$/kg ☐ x10$^7$/kg ☐ x10$^8$/kg |
| CD34+ cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^5$/kg ☐ x10$^6$/kg |
| CD3+ cells (/kg) | _____ ☐ Not evaluated ☐ Unknown | ☐ x10$^5$/kg ☐ x10$^6$/kg ☐ x10$^7$/kg ☐ x10$^8$/kg |

***Was the graft cryopreserved prior to infusion?**
- ☐ No
- ☐ Yes; ***Date of cryopreservation:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* ☐ Unknown
- ☐ Unknown

*Extended dataset*

### Cord blood

***Cell infusion for this product**

***Route:** ☐ Intravenous (IV) ☐ Intrabone/intramedullary ☐ Other; specify: _____ ☐ Unknown

***Method:** ☐ DMSO ☐ Wash (Rubinstein/New York) ☐ Other; specify: _____ ☐ Unknown

***Cell viability tests performed at HCT centre:** ☐ No ☐ Yes;

***Tests performed after thawing of an aliquot on:** ☐ Contiguous segment ☐ Reference bag ☐ Unknown

***Method used:** ☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium bromide ☐ Acridine orange-ethidium iodide ☐ Other; specify _____ ☐ Unknown

***Viability of all cells:** _____ % ☐ Unknown

***Viability of CD34+ cells:** _____ % ☐ Unknown

## DONOR INFORMATION
### --- Donor __(number) continued ---
*Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.*

***Relation between patient and donor:** ☐ Related:

**Relationship to patient:**
- ☐ Syngeneic (monozygotic twin)
- ☐ Sibling *(may include non-monozygotic twin)*
- ☐ Other related:
  - ☐ Parents
  - ☐ Child
  - ☐ Aunt/Uncle
  - ☐ Cousin
  - ☐ Grand Parents
  - ☐ Other; specify: _____

☐ Unrelated *(proceed to next page)*

## Related donor:

***Both haplotypes confirmed by family studies?**
*(for both matched and mismatched related donors)*
- ☐ No
- ☐ Yes
- ☐ Unknown

***HLA match type:**

☐ *Match (both haplotypes matched)

☐ *Mismatch:

***Method used for patient/donor HLA typing:** *(select all that apply)*
- ☐ Molecular
- ☐ Serology

**if molecular typing was done:**

| *Locus: | *Number of mismatches, allelic: |
|---|---|
| A: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| B: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| C: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DRB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DQB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DPB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |

**if serological typing was done:**

| *Locus: | *Number of mismatches, antigenic: |
|---|---|
| A: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| B: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| C: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DRB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DQB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DPB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |

***Please enter the LABORATORY RESULTS WITH HLA TYPING into the database for all the donors***

**DONOR INFORMATION**
**--- Donor __(number) continued ---**
*Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.*

## Unrelated donor:

***HLA match type:**

***Method used for patient/donor HLA typing:** *(select all that apply)*
☐ Molecular
☐ Serology

**if molecular typing was done:**

| ***Locus:** | ***Number of mismatches, allelic:** |
|---|---|
| A: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| B: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| C: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DRB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DQB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DPB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |

**if serological typing was done:**

| ***Locus:** | ***Number of mismatches, antigenic:** |
|---|---|
| A: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| B: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| C: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DRB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DQB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |
| DPB1: | ☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated |

***Please enter the LABORATORY RESULTS WITH HLA TYPING into the database for all the donors***

## ADDITIONAL ASSESSMENTS
(All diagnoses)

**Are there Donor-Specific Antibodies (DSA) against HLA?**

☐ No

☐ Yes: **HLA loci the DSA are directed against:** ☐ A ☐ B ☐ C ☐ DRB1 ☐ DQB1 ☐ DPB1

**Did the patient have desensibilisation therapy?** ☐ No
*(Haemoglobinopathies only)* ☐ Yes; specify: _____

**Are the DSA red cell antibodies?** ☐ No
*(Haemoglobinopathies only)* ☐ Yes: **Are they cross-reacting with the red cells of the donor?** ☐ No ☐ Yes

☐ Not evaluated

☐ Unknown

## PREPARATIVE REGIMEN
(All Diagnoses)

**Preparative (conditioning) regimen given?**

☐ No

☐ Yes

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

☐ No

☐ Yes (provide details in the table on pages 10-11)

**What type of conditioning regimen was used?**

☐ Reduced intensity conditioning (RIC)

☐ Myeloablative conditioning (MAC)

## 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.*
*Report dosages and units only for individual drugs.)*

| Chemotherapy | Dose | Unit |
|---|---|---|
| ☐ Bendamustine | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Bleomycin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Busulfan<br>Route of administration: ☐ Oral ☐ IV ☐ Both<br>Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Carboplatin<br>Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Carmustine | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Cisplatin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Clofarabine | _____ | ☐ mg/m² ☐ mg/kg |
| **Corticosteroids:** | | |
| ☐ Beclometasone | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Budesonide | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Dexamethasone | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Methylprednisolone | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Prednisolone | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Cyclophosphamide | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Cytarabine | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Daunorubicin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Doxorubicin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Epirubicin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Etoposide | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Fludarabine | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Gemtuzumab ozogamicin | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Ibritumomab tiuxetan | _____ | ☐ mCi ☐ MBq |
| ☐ Idarubicin | _____ | ☐ mg/m² ☐ mg/kg |

## 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 | Units |
|---|---|---|
| ☐ Ifosfamide | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Imatinib | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Lomustine | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Melphalan | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Mitoxantrone | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Paclitaxel | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Anti-CD20 antibodies | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Teniposide | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Thiotepa | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Tositumomab | _____ | ☐ mCi ☐ MBq |
| ☐ Treosulfan | _____ | ☐ mg/m² ☐ mg/kg |
| ☐ Other; specify*: _____ | _____ | ☐ mg/m² ☐ mg/kg<br>☐ mCi ☐ 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:** _____

**Total lymphatic irradiation (TLI):**

☐ No

☐ Yes; **Total prescribed radiation dose as per protocol:** _____ Gy

**Number of fractions:** _____

**Number of radiation days:** _____

**Total abdominal irradiation (TAI):**

☐ No

☐ Yes; **Total prescribed radiation dose as per protocol:** _____ Gy

**Number of fractions:** _____

**Number of radiation days:** _____

## GvHD PREVENTIVE TREATMENT

**GvHD preventive treatment:**

☐ No

☐ Yes: indicate the drugs

☐ Abatacept

☐ Alemtuzumab

☐ Anti-Thymocyte Globulin (ATG) | Anti-Lymphocyte Globulin

Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____

Anti-Thymocyte Globulin (ATG) total cumulative dose (mg/kg): ___ ☐ Unknown

☐ Basiliximab

**Corticosteroids:**

☐ Beclometasone

☐ Budesonide

☐ Dexamethasone

☐ Methylprednisolone

☐ Prednisolone

☐ Cyclophosphamide Post Transplant Cyclophosphamide (PTCY) cumulative dose (mg/kg): _____ ☐ Unknown

Post Transplant Cyclophosphamide (PTCY) timing schedule: ☐ Single dose on day 3 ☐ Single dose on day 5 ☐ Doses on days 3 and 4 ☐ Doses on days 3 and 5 ☐ Other, specify: _____

☐ Cyclosporine

☐ Etanercept

☐ Everolimus

☐ Infliximab

☐ Methotrexate

☐ Mycophenolate mofetil

☐ Ruxolitinib

☐ Sirolimus

☐ Tacrolimus

☐ Other agent (in vivo); specify*: _____

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

***END OF THE ALLO-HCT DAY 0 REPORT***

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