



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)

CHRONIC LEUKAEMIAS

DISEASE

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

Date of diagnosis: ____/____/____ (YYYY/MM/DD)

Classification (WHO 2022):

- Chronic myeloid leukaemia (CML)
- Chronic lymphocytic leukaemia (CLL) / small lymphocytic lymphoma (SLL) / Richter transformation
- Prolymphocytic (PLL) and other chronic leukaemias

Chronic Myeloid Leukaemias (CML)

CHROMOSOME ANALYSIS

Describe results of all the analysis done before HCT/CT treatment

Chromosome analysis done before HCT/CT treatment:

- No
 Yes: **Output of analysis:** Separate abnormalities Full karyotype
 Unknown

Copy and fill-in this section as often as necessary.

If chromosome analysis was done:

What were the results?

- Normal
 Abnormal: number of abnormalities present: _____
 Failed

Date of chromosome analysis: ____/____/____ (YYYY/MM/DD) Unknown

For abnormal results, indicate below whether the abnormalities were absent, present or not evaluated.

t(9;22)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Trisomy 8	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Extra Ph	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
i(17)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
-7/Del	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
3q26	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Other; specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

OR

Transcribe the complete karyotype: _____

MOLECULAR MARKER ANALYSIS

Molecular markers analysis done before HCT/CT treatment:

- No
 Yes
 Unknown

Copy and fill-in this section as often as necessary.

If molecular marker analysis was done:

Date of molecular marker analysis: ____/____/____ (YYYY/MM/DD) Unknown

Indicate below whether the markers were absent, present or not evaluated.

ASXL1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
BCORL1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
BCR::ABL1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
CBFB-MYH11	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
EZH2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
IDH1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
IKZF1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
KMT2D	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
RUNX1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
SETD1B	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
TET2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
TP53	<input type="checkbox"/> Absent	<input type="checkbox"/> Present:	<input type="checkbox"/> Not evaluated
TP53 mutation type: <input type="checkbox"/> Single hit <input type="checkbox"/> Multi hit <input type="checkbox"/> Unknown			
Other; specify _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

PREVIOUS THERAPIES

(between diagnosis and HCT/CT)

Previous therapy lines before the HCT/CT/GT:

- No
 Yes: complete the "Treatment — non-HCT/CT/GT/IST" form
 Unknown

Chronic Lymphocytic Leukaemias (CLL)

DISEASE

Sub-Classification (WHO 2022):

Chronic lymphocytic leukaemia (CLL) / small lymphocytic lymphoma (SLL)

Richter transformation:

Transformed from a previous known CLL: No (primary Richter)

Yes; **Date of original CLL diagnosis:** ____/____/____ (YYYY/MM/DD)

Unknown

Type of Richter transformation:

Hodgkin

DLBCL

Other; specify: _____

Richter transformation clonally related to CLL: No

Yes

CHROMOSOME ANALYSIS

Describe results of all the analysis done before HCT/CT treatment

Chromosome analysis done before HCT/CT treatment:

- No
- Yes: **Output of analysis:** Separate abnormalities Full karyotype
- Unknown

Copy and fill-in this section as often as necessary.

If chromosome analysis was done:

What were the results?

- Normal
- Abnormal: number of abnormalities present: _____
- Failed

Date of chromosome analysis: ____/____/____ (YYYY/MM/DD) Unknown

For abnormal results, indicate below whether the abnormalities were absent, present or not evaluated.

Trisomy 12	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(13q14)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(11q22-23)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(17p)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Other; specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

OR

Transcribe the complete karyotype: _____

MOLECULAR MARKER ANALYSIS

Molecular markers analysis done before HCT/CT treatment:

- No
- Yes
- Unknown

Copy and fill-in this section as often as necessary.

If molecular marker analysis was done:

Date of molecular marker analysis: ____/____/____ (YYYY/MM/DD) Unknown

IGVH mutational status: Absent Present **High risk subset?** No Yes

Indicate below whether the markers were absent, present or not evaluated.

TP53	<input type="checkbox"/> Absent	<input type="checkbox"/> Present;	<input type="checkbox"/> Not evaluated
		TP53 mutation type:	<input type="checkbox"/> Single hit
			<input type="checkbox"/> Multi hit
			<input type="checkbox"/> Unknown
Other; specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

PREVIOUS THERAPIES (between diagnosis and HCT/CT)

Previous therapy lines before the HCT/CT:

- No
- Yes:

complete the "Treatment — non-HCT/CT/GT/IST" form
- Unknown

Prolymphocytic (PLL) and Other Chronic Leukaemias

DISEASE

Sub-Classification (WHO 2022): Prolymphocytic and other chronic leukaemias

- T-prolymphocytic leukaemia (T-PLL)
- Hairy cell leukaemia
- Splenic B-cell lymphoma/leukaemia with prominent nucleoli (SBLPN)
- Other chronic leukaemia; specify: _____

CHROMOSOME ANALYSIS - *only applicable for T-PLL*

Describe results of all the analysis done before HCT/CT treatment

Chromosome analysis done before HCT/CT treatment:

- No
- Yes: output of analysis: Separate abnormalities Full karyotype
- Unknown

Copy and fill-in this section as often as necessary.

If chromosome analysis was done:

What were the results?

- Normal
- Abnormal: number of abnormalities present: _____
- Failed

Date of chromosome analysis: ____/____/____ (YYYY/MM/DD) Unknown

For abnormal results, indicate below whether the abnormalities were absent, present or not evaluated.

inv(14) t(14;14)(q11;q32)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(14)(q12)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
t(11;14)(q23;q11)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
t(7;14)(q35;q32.1)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
t(X;14)(q35;q11)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
idic(8)(p11)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(17p)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Other; specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

OR

Transcribe the complete karyotype: _____

IMMUNOPHENOTYPING
only applicable for T-PLL

Immunophenotype of T-cells at diagnosis:

Note: Terminal deoxynucleotidyl transferase (TdT) must be negative.

Indicate below whether the phenotypes were absent, present or not evaluated.

CD4+	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
CD8+	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown

Lymphocyte count at diagnosis: _____ 10⁹ cells/L Not evaluated Unknown

Was mantle cell lymphoma excluded at diagnosis?:

- No
- Yes; **method:** FISH on t(11;14)(q23;q11)
 - Cyclin D1 expression
 - Both
 - Other
- Unknown