



EBMT Centre Identification Code (CIC): _____

Treatment Type IST

Hospital Unique Patient Number (UPN): _____

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

Patient Number in EBMT Registry: _____

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 1st 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 1st 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

<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*: _____

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