

## Recipient Follow-up (Post Allogeneic Stem Cell Transplantation)

Patient Name:  
Patient DOB:  
Patient ID:  
GRID:  
Transplant Center:

Date of Donation:

Patient alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No, date of death _____ (yyyy/mm/dd)
If yes, patient last seen on:	_____ (yyyy/mm/dd)	
If no, reason of death?	<input type="checkbox"/> GvHD	<input type="checkbox"/> Relapse
	<input type="checkbox"/> Sepsis	<input type="checkbox"/> MOF
	<input type="checkbox"/> Infection	<input type="checkbox"/> Other: _____
HPC product infused?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharged from hospital?	<input type="checkbox"/> Yes, day + _____	<input type="checkbox"/> No
If no, reason:	<input type="checkbox"/> GvHD	<input type="checkbox"/> Relapse
	<input type="checkbox"/> Sepsis	<input type="checkbox"/> MOF
	<input type="checkbox"/> Infection	<input type="checkbox"/> Other: _____
Patient lost to follow-up?	<input type="checkbox"/>	
Engraftment:: ANC >500/ $\mu$ l	day + _____	not achieved <input type="checkbox"/>
		not performed <input type="checkbox"/>
WBC>1000/ $\mu$ l (only if ANC not performed)	day + _____	not achieved <input type="checkbox"/>
		never below <input type="checkbox"/>
Platelets>20/ $\mu$ l (w/o platelet transfusions)	day + _____	not achieved <input type="checkbox"/>
		never below <input type="checkbox"/>
Adverse events during transplant infusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:	_____	
Recurrence of original disease?	<input type="checkbox"/> Yes, day + _____	<input type="checkbox"/> No
If yes, meanwhile successfully treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acute GvHD?	<input type="checkbox"/> None	<input type="checkbox"/> Grade I
	<input type="checkbox"/> Grade II	<input type="checkbox"/> Grade III
	<input type="checkbox"/> Grade IV	
If yes, please specify (organ/s):	_____	
Infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:	_____	
If yes, meanwhile successfully treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient been re-transplanted, or given T-cells?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:	<input type="checkbox"/> PBSC	<input type="checkbox"/> BM
	<input type="checkbox"/> DLI	
Source of cells:	<input type="checkbox"/> the same unrelated donor	<input type="checkbox"/> other unrelated donor
	<input type="checkbox"/> related	
If related, please specify :	<input type="checkbox"/> identical	<input type="checkbox"/> mismatched
	<input type="checkbox"/> haploidentical	
Karnofsky <input type="checkbox"/> / Lansky <input type="checkbox"/> / ECOG <input type="checkbox"/> score:	Calculated on _____ (yyyy/mm/dd)	
Form completed by:	Signature:	Date: _____ (yyyy/mm/dd)

Please send back to: Followup@dkms.cl