

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 _____ <small>(yyyy/mm/dd)</small>
If yes, patient last seen on:	_____ <small>(yyyy/mm/dd)</small>	
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: _____	
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/ μ l	day + _____	not achieved <input type="checkbox"/>
		not performed <input type="checkbox"/>
WBC >1000/ μ l <small>(only if ANC not performed)</small>	day + _____	not achieved <input type="checkbox"/>
		never below <input type="checkbox"/>
Platelets >20/ μ l <small>(w/o platelet transfusions)</small>	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 _____ <small>(yyyy/mm/dd)</small>	
Form completed by:	Signature: _____	Date: _____ <small>(yyyy/mm/dd)</small>

Please send back to: followup@dkms-bmst.org