

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: _____
Patient lost to follow-up?	<input type="checkbox"/>	
Patient readmitted to hospital?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
If yes, 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: _____
If yes, patient discharged afterwards?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
Recurrence of original disease?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
If yes, meanwhile successfully treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic GvHD?	<input type="checkbox"/> None	<input type="checkbox"/> Mild
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
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
Secondary graft failure?	<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
Source of cells:	<input type="checkbox"/> the same unrelated donor	<input type="checkbox"/> other unrelated donor
If related, please specify :	<input type="checkbox"/> identical	<input type="checkbox"/> mismatched
	<input type="checkbox"/> related	<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-bmst.org

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