DKMS WIR BESIEGEN BLUTKREBS

DKMS gemeinnützige GmbH
Kressbach 1
72072 Tübingen, **Germany**

Contact: Donor-Patient Contacts
T +49 7071 943 2303
F +49 7071 943 1399
Donor2patient@dkms.de

Recipient Follow-up (Post Allogeneic Stem Cell Transplantation)

Patient Name: ____________
Patient DOB: __/__/_______
Patient ID: _____ / EMDIS
GRID: ______________________________
Transplant Center: _____________________________
____
____

Date of Donation: __/__/______

CCC Cellex Collection Center GmbH

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

Please send back to: Fax +49 7071 943 1399 or donor2patient@dkms.de **3M**