DKMS
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Donor-Patient Contacts
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Recipient Follow-up (Post Allogeneic Stem Cell Transplantation)

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

Date of Donation:

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:_____				
Patient lost to follow-up?	☐				
Patient readmitted to hospital?	☐ Yes, on _____ (yyyy/mm/dd)		☐ No		
If yes, reason:	☐GvHD	☐Relapse	☐Sepsis	☐MOF	☐Infection
	☐Other:_____				
If yes, patient discharged afterwards?	☐ Yes, on _____ (yyyy/mm/dd)		☐ No		
Recurrence of original disease?	☐ Yes, on _____ (yyyy/mm/dd)		☐ No		
If yes, meanwhile successfully treated?	☐ Yes		☐ No		
Chronic 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	
Secondary graft failure?		☐ 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: Followup@dkms.cl **annual**