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## Patient 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 | ☐ Mild | ☐ Moderate | ☐ Severe | | |
| 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: Fax: +48 22 882 96 82 or popobraniu@dkms.pl*** **annual**