

n° : _____ Date: ___/___/___



Stem cell transplantation
- follow-up -

To be completed by the transplant center

PATIENT DATA:

Patient name:	Patient ID number:
Date of birth: (mm/dd/yyyy)	Date of transplant: (mm/dd/yyyy)
Date of last contact: (mm/dd/yyyy)	Transplant center:
Donor ID:	Donor Registry:

BMT FOLLOW-UP AFTER:

Month :	1	3	6	Year :	1	2	3	4	5
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PRODUCT DATA:

- Was the full stem cell product used at once for transplantation? Infusion date:(mm/dd/yyyy)	Yes	No
- Was any portion of the stem cell product stored for later infusion? - If yes, was this portion later infused into the patient? Infusion date:(mm/dd/yyyy)	Yes	No
- Was any unused portion of the stem cell product discarded? - If yes, please provide date and detailed explanation of disposal: Disposal date:(mm/dd/yyyy) Method:.....	Yes	No

PATIENT FOLLOW-UP DATA:

Is the patient alive? If no, date of death:(mm/dd/yyyy)	Yes	No	Primary cause of death:.....	
Did the stem cells engraft? If yes, date engraftment:(mm/dd/yyyy)	Yes	Partial	No	
Rejection or graft failure? If yes, please specify date:(mm/dd/yyyy)	Yes	No		
Acute GvHD If yes, grade:	Grade I	Grade II	Grade III	Grade IV
Chronic GvHD If yes, extent:	Mild	Moderate	Severe	
Recurrence of original disease?	Yes	No		
Has the patient been:	re-transplanted	Yes	No	
	Given lymphocyte infusions	Yes	No	
If yes to either, source of stem cells/lymphocytes:				
Karnofsky/Landsky score:				
Additional comments/complications:				

Person Completing Form:	Signature:	Date (mm/dd/yyyy)
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