

**AUSTRALASIAN BONE MARROW TRANSPLANT RECIPIENT REGISTRY
ANNUAL FOLLOW UP**

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Hospital : _____ Patient UPN: _____ DOB: ____/____/____
 Patient name ID: _____ Transplant date: ____/____/____
 Person completing this form: _____ Follow Up period: Year ____ post transplant

1. Survival status alive dead
 Last known date of contact/death: ____/____/____
 If dead, **main** cause of death: (select only one main cause)
 Relapse/Progression/Persistent disease
 New malignancy
 Transplant related (select as many as appropriate)
 Cardiac toxicity Haemorrhage
 GvHD Multi-organ failure
 Rejection/poor graft function Pulmonary toxicity
 VOD Renal failure
 Infection, specify organism: _____
 Other tx related: _____
 Other, specify _____
 Unknown
 Comments: _____

1a. Last known disease status
 CR not in CR N/A (non-malignant disease)
 Date assessed: ____/____/____
2. Best disease status achieved post transplant, prior to treatment modification (not applicable for non-malignant diseases)
 Continued CR
 CR achieved, date achieved: ____/____/____
 Never in CR, date of last assessment: ____/____/____
 Previously reported

2a. Did graft failure occur? Yes No

3. First Relapse or Progression Post Transplant?
 No, date last assessed ____/____/____
 Yes, date first detected by haematological or clinical method ____/____/____

Leukaemia only, if detected by following methods
 cytogenetic date assessed ____/____/____
 molecular date assessed ____/____/____

 or previously reported

4. Did a new malignancy, lymphoproliferative or myeloproliferative disorder occur? Yes No
 If yes, specify diagnosis _____
 date of diagnosis: ____/____/____

5. Performance Status at this year's follow-up
 (Karnofsky or Lansky Score) Estimate Documented
 Date of assessment: ____/____/____

6. Chronic Graft versus Host Disease (Allografts only)
 Is patient currently on immunosuppression?
 Yes No Unknown
 Immunosuppression date ceased ____/____/____ (if previously given)
 Date of **first** incidence of chronic GvHD: ____/____/____
 or previously reported
 Was cGvHD present during this period? Yes No

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Maximum grade during this period (NIH criteria)
 Mild Moderate Severe Unknown
 Maximum Extent during this period
 Limited Extensive
 Organs affected: (Tick all that apply)
 skin mouth
 intestinal tract eyes
 liver
 Other organ(s): specify _____

7. Donor Cellular Infusion (up to 1st year post transplant only)
 Additional cell therapy given? Yes No

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First infusion date ____/____/____
 Cell type: Lymphocytes Mesenchymal
 Other, specify _____
 Indication:
 Planned Treat GVHD
 Treat disease Mixed chimerism
 Treat PTLD, EBV-Lym Loss/decrease chimerism
 Treat viral Other, specify _____