

**Recipient Follow-up (Post Allogeneic Stem Cell Transplantation)**

Patient Name:  
Patient DOB:  
Patient ID:  
Donor ID:  
Transplant Center:

Date of Donation:

Patient alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No, date of death _____ (yyyy/mm/dd)
If yes, patient last seen on:	_____ (yyyy/mm/dd)	
If no, reason of death?	<input type="checkbox"/> GvHD <input type="checkbox"/> Relapse <input type="checkbox"/> Sepsis <input type="checkbox"/> MOF <input type="checkbox"/> Infection <input type="checkbox"/> Other: _____	
Patient lost to follow-up?	<input type="checkbox"/>	
Patient readmitted to hospital?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
If yes, reason:	<input type="checkbox"/> GvHD <input type="checkbox"/> Relapse <input type="checkbox"/> Sepsis <input type="checkbox"/> MOF <input type="checkbox"/> Infection <input type="checkbox"/> Other: _____	
If yes, patient discharged afterwards?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
Recurrence of original disease?	<input type="checkbox"/> Yes, on _____ (yyyy/mm/dd)	<input type="checkbox"/> No
If yes, meanwhile successfully treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic GvHD?	<input type="checkbox"/> None <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV If yes, please specify (organ/s): _____	
Infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:	_____	
If yes, meanwhile successfully treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Secondary graft failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient been re-transplanted, or given T-cells?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:	<input type="checkbox"/> PBSC <input type="checkbox"/> BM <input type="checkbox"/> DLI Source of cells: <input type="checkbox"/> the same unrelated donor <input type="checkbox"/> other unrelated donor <input type="checkbox"/> related If related, please specify : <input type="checkbox"/> identical <input type="checkbox"/> mismatched <input type="checkbox"/> haploidentical	
Karnofsky <input type="checkbox"/> / Lansky <input type="checkbox"/> / ECOG <input type="checkbox"/> score:	Calculated on _____ (yyyy/mm/dd)	
Form completed by:	Signature:	Date: _____ (yyyy/mm/dd)