DKMS
WIR BESIEGEN BLUTKREBS

Please send back to: Fax +49 7071 943 1399 or donor2patient@dkms.de

Recipient Follow-up (Post Allogeneic Stem Cell Transplantation)

Patient Name:
Patient DOB:
Patient ID:
Donor ID:
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:_____				
HPC product infused?	☐ Yes	☐ No			
Discharged from hospital?	☐ Yes, day + _____		☐ No		
If no, reason:	☐GvHD	☐Relapse	☐Sepsis	☐MOF	☐Infection
	☐Other:_____				
Patient lost to follow-up?	☐				
Engraftment:: ANC >500/µl		day + _____	not achieved ☐		
			not performed ☐		
WBC>1000/µl		day + _____	not achieved ☐		
(only if ANC not performed)			never below ☐		
Platelets>20/µl		day + _____	not achieved ☐		
(w/o platelet transfusions)			never below ☐		
Adverse events during transplant infusion?		☐ Yes	☐ No		
If yes, please specify:	_____				
Recurrence of original disease?		☐ Yes, day + _____	☐ No		
If yes, meanwhile successfully treated?		☐ Yes	☐ No		
Acute 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		
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)		

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