Bone Marrow or Peripheral Blood Stem Cell (PBSC) Transplantation
Follow-up at 12 months

Patient's Initials _____ Patient's ID # _____ IBMTR/EBMTR ID # _____	Person Completing Form _____ Date ___ / ____ / ____ Date of BMT ___ / ____ / ____ MM/DD/YY MM/DD/YY
Patient Status □ Alive □ Dead Date of Death _____ / _____ / _____ Cause of Death _____ _____	Problems During the Reported 12 Month Period □ None □ Chronic GvHD Grade □ I/II □ III □ IV Localization □ Skin □ Liver □ Intestines □ Severe Infections _____ □ Other (specify)* _____ _____
Outcome Bone Marrow □ Engrafted Date _____ / _____ / _____ □ Rejected Date _____ / _____ / _____	Bone Marrow Function Date of Last Transfusion Erythrocytes _____ / _____ / _____ Frequency/wk _____ Platelets _____ / _____ / _____ Frequency/wk _____ Cytokines (eg: G-CSF) still required? □ No □ Yes (specify)* _____ _____
Name, Address, Telephone – for further questions	

*please use back side or extra page if space is not sufficient

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