

Bone Marrow or Peripheral Blood Stem Cell (PBSC) Transplantation Follow-up at 6 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 6 Month Period None Chronic GvHD Grade I/II III IV Localization Skin Liver Intestines Severe Infections _____ Other (specify)* _____ _____
Outcome Bone Marrow Engrafted Date ____ / ____ / ____ Chimerism (% donor cells) _____ 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