Bone Marrow or Peripheral Blood Stem Cell (PBSC) Transplantation

Patient's Initials _____

Patient's ID # _____

IBMTR/EBMTR ID# _____

Person Completing Form

_____

Date ____/____/____ Date of BMT ____/____/____
DD/MM/YY DD/MM/YY

Reason For BMT

□ Neutropenia

□ No cytokine therapy available.

□ Non-responder to G-CSF or other cytokine.

(brand name/dose)*

_____

□ Leukemia □ MDS □ Monosomy 7

□ Other (specify)* _____

Source of

Stem Cells □ BM □ PBSC □ Cordblood

Graft □ Allogenic □ Autologous

Donor □ HLA-Identical Sibling

□ Matched Unrelated Donor

Other _____

_____

Marrow Ablative Therapy

TBI □ No □ Yes

Dose _____

Cyclophosphamide □ No □ Yes

Dose _____

Busulfan □ No □ Yes

Dose _____

Other (brand name/dose)*

_____

_____

Complications

□ None

□ Acute 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 ____ / ____ / ____

Patient Status

□ Released Date ____ / ____ / ____

□ Still Hospitalized Date ____ / ____ / ____

□ Death Date ____ / ____ / ____

Cause* _____

Bone Marrow Function

Date of Last Transfusion

Erythrocytes _____

Frequency (e.g. once/wk) _____

Platelets _____

Frequency (e.g. once/wk) _____

Cytokines (e.g. 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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