

# Leukemia/MDS Transformation

Patient Name _____ Patient Initials / SCNIR # _____ Person Completing Form _____ Date ____ / ____ / ____	Patient Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead Date ____ / ____ / ____ Cause _____
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**SECTION 1 - Diagnosis**

Leukemia Date of Diagnosis ____ / ____ / ____ <input type="checkbox"/> AML FAB Type <input type="checkbox"/> M0 <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> M3 <input type="checkbox"/> M4 <input type="checkbox"/> M4OE <input type="checkbox"/> M5 <input type="checkbox"/> M5A <input type="checkbox"/> M5B <input type="checkbox"/> M6 <input type="checkbox"/> M7 <input type="checkbox"/> ALL <input type="checkbox"/> Other (specify) _____	MDS Date of Diagnosis ____ / ____ / ____ <input type="checkbox"/> Refractory Anemia (RA) <input type="checkbox"/> RA in Leukemic Transformation <input type="checkbox"/> RA w/ ringed sideroblasts (RARS) <input type="checkbox"/> RA w/excess Myeloblasts (RAEB) <input type="checkbox"/> Chronic Myelomonocytic Leukemia (CMML) <input type="checkbox"/> Juvenile Myelomonocytic Leukemia (JMML) <input type="checkbox"/> Other (specify) _____
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**SECTION 2 – Treatment Planned and/or Received**

Chemotherapy <input type="checkbox"/> No <input type="checkbox"/> Yes Start Date ____ / ____ / ____ Type (protocol/medication) _____ _____ _____	Cytokine Therapy <input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____ Red Cell Transfusions <input type="checkbox"/> No <input type="checkbox"/> Yes Steroids <input type="checkbox"/> No <input type="checkbox"/> Yes Platelets <input type="checkbox"/> No <input type="checkbox"/> Yes Other Treatment Planned _____
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**SECTION 3**

Date Diagnostic Bone Marrow (attach report) ____ / ____ / ____ List any Symptoms in Months Preceding Leukemia or MDS Diagnosis – e.g. Splenomegaly _____ _____ Cytogenetics at Time of Transformation (attach report) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of Cytogenic Evaluation ____ / ____ / ____ Bone Marrow Transplant <input type="checkbox"/> No <input type="checkbox"/> Yes (complete BMT form) Date of BM Transplant ____ / ____ / ____ Source of Stem Cells <input type="checkbox"/> Bone Marrow <input type="checkbox"/> PBSC <input type="checkbox"/> Cordblood Type of Transplant <input type="checkbox"/> Allogenic <input type="checkbox"/> Autologous Donor <input type="checkbox"/> HLA-Identical Sibling <input type="checkbox"/> MUD	CBC/FBC and Differential at time of Transformation Red Blood Cells _____ Neutrophils _____ Hemoglobin _____ Lymphocytes _____ MCV _____ Eosinophils _____ Platelets _____ Basophils _____ White Blood Cells _____ Other (type) _____ Current Cytokine Therapy - G-CSF/Other Type _____ <input type="checkbox"/> Continued Dose _____ <input type="checkbox"/> Same <input type="checkbox"/> Reduced <input type="checkbox"/> Interrupted, Resumed Dose ____ <input type="checkbox"/> Same <input type="checkbox"/> Reduced <input type="checkbox"/> Discontinued Date ____ / ____ / ____ Current Bone Marrow Status of Patient <input type="checkbox"/> Remission <input type="checkbox"/> Stable/No Response <input type="checkbox"/> Progression <input type="checkbox"/> Relapse
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**COMMENTS**

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