

This follow-up form is completed \_\_\_\_\_ month(s) after stem cell transplantation.

RECIPIENT DATA	
Recipient first name:	Recipient last name:
Recipient registry:	
Transplant centre:	
Recipient ID: <small>(assigned by patient registry)</small>	Date of birth: <small>(YYYY-MM-DD)</small>
Date of transplant: <small>(YYYY-MM-DD)</small>	Date of last contact: <small>(YYYY-MM-DD)</small>

DONOR DATA	
Donor registry:	ION:
Donor ID:	
GRID:	

FOLLOW-UP DATA	
Was the full stem cell product used at once for transplantation? <input type="radio"/> Yes <input type="radio"/> No	Infusion date: <small>(YYYY-MM-DD)</small>
Was any portion of the stem cell product stored for later infusion? <input type="radio"/> Yes <input type="radio"/> No	Amount stored:
If yes, was this portion later infused into the recipient? <input type="radio"/> Yes <input type="radio"/> No	Infusion date: <small>(YYYY-MM-DD)</small>
Was any unused portion of the stem cell product discarded? <input type="radio"/> Yes <input type="radio"/> No	
If yes, please provide date and detailed explanation of disposal: Method:	Disposal date: <small>(YYYY-MM-DD)</small>
Is the recipient alive? <input type="radio"/> Yes <input type="radio"/> No	If not, date of death: <small>(YYYY-MM-DD)</small>
Primary cause of death:	
Contributing cause(s) of death:	
Was the stem cell product infused prior to recipient death? <input type="radio"/> Yes <input type="radio"/> No	
If not, please provide a detailed explanation of the disposal:	
Did the stem cells engraft? <input type="radio"/> Yes, complete <input type="radio"/> Partial <input type="radio"/> No	If yes, date engraftment: <small>(YYYY-MM-DD)</small>
Rejection or graft failure? <input type="radio"/> Yes <input type="radio"/> No	If yes, please specify date: <small>(YYYY-MM-DD)</small>
Acute GvHD: <input type="radio"/> Yes <input type="radio"/> No If yes, grade: <input type="radio"/> Grade I <input type="radio"/> Grade II <input type="radio"/> Grade III <input type="radio"/> Grade IV	
Relapse: <input type="radio"/> Yes <input type="radio"/> No	
Has recipient been: Re-transplanted? <input type="radio"/> Yes <input type="radio"/> No	
Given lymphocyte infusions? <input type="radio"/> Yes <input type="radio"/> No	
If yes to either, source of stem cells/lymphocytes:	
How well is the recipient recovering?	
Additional comments:	

Transplant centre representative:	Date: <small>(YYYY-MM-DD)</small>	Signature:
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