



Marrow Donor Program Belgium - Registry
Motstraat 40 2800 Mechelen
Tel: (32) - 15 44 33 96 Fax: (32) - 15 44 36 56
Email : MDPB-registry@rodekruis.be

PATIENT POST TRANSPLANT FOLLOW-UP REPORT
3 MONTHS – 1 YEAR

Recipient Name:		
Recipient ID:		
DOB:		
Primary Diagnosis:		
Donor ID:		
Transplant Center:		
Date of transplant:		
Is this report on a second transplant? <i>If Yes, specify indication:</i> <i>If Yes, specify the date of first transplant:</i>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
	<input type="checkbox"/> 3 months	
	<input type="checkbox"/> 1 year	
Recipient ALIVE <i>If no, Date of death:</i> <i>Principal cause of death:</i>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
ENGRAFTMENT ANC > 500/μl Platelet engraftment > 20000/μl – 50000/μl	day + <input type="checkbox"/> not achieved <input type="checkbox"/> not performed	
	day + <input type="checkbox"/> not achieved	
	<input type="checkbox"/> Complete	
	<input type="checkbox"/> Partial	
R.I.C. (Reduced Intensity Conditioning)	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
COMPLICATIONS ACUTE GVHD <i>If Yes, Grade</i>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
		<i>(I, II, III, IV)</i>
CHRONIC GVHD <i>If Yes, to what extent</i>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
	<input type="checkbox"/> Mild	
	<input type="checkbox"/> Moderate	
	<input type="checkbox"/> Severe	
INFECTION <i>If Yes, specify infection:</i>	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	



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Recipient Name:	
Recipient ID:	

RECURRENCE of the original disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No
REJECTION or graft failure:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please give date:</i>	
KARNOFSKY/LANSKY rating:	
Has the recipient been re-transplanted after this transplantation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Yes, specify indication:</i>	<input type="checkbox"/> Relapse <input type="checkbox"/> Graft failure <input type="checkbox"/> Decreasing chimerism
<i>If Yes, specify donor ID (if unrelated donor):</i>	
<i>If Yes, source of stem cells:</i>	<input type="checkbox"/> BM/PBSC <input type="checkbox"/> Mesenchymal SC <input type="checkbox"/> Haploidentical SC
Has the recipient received DLI after this transplantation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Yes, specify indication:</i>	<input type="checkbox"/> Relapse <input type="checkbox"/> Decreasing chimerism <input type="checkbox"/> Infections <input type="checkbox"/> Preemptive
<i>If Yes, specify donor ID:</i>	
Comments:	
Name of person completing the form:	
Date:	