



**CORD BLOOD POST TRANSPLANT FOLLOW-UP REPORT (HPC, CB)**  
**3 MONTHS - 1 YEAR**

Recipient Name:	
Recipient ID:	
DOB (dd/mm/yyyy):	
Primary Diagnosis:	
CBU ID:	
Cord Blood Bank:	
Cord Blood Bank address:	
Transplant Center:	
Date of transplant:	

<b>CORD TRANSPLANT FOLLOW-UP</b>	<input type="checkbox"/>	3 months
	<input type="checkbox"/>	1 year

<b>Recipient ALIVE</b>	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No
<i>If No, Date of death:</i>		
<i>Principal cause of death:</i>		
<i>Contributory cause of death:</i>		
<i>Date of lost follow-up:</i>		

<b>CBU used for</b>	<b>ex-vivo expansion</b>	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
	<b>other purposes</b>	<input type="checkbox"/>	Yes
	<i>If Yes, please provide detailed information:</i>	<input type="checkbox"/>	No
<b>KIND OF TRANSPLANTATION</b>		<input type="checkbox"/>	Single
		<input type="checkbox"/>	Double (simultaneous)
		<input type="checkbox"/>	Subsequent (patient received another transplant before)
<b>Number of cells transplanted</b>	<b>Number of CD34 cells/kg body weight</b>		
	<b>Number of TNC/kg body weight</b>		
<b>Results on thawed CBU - viability:</b>			
<b>Adverse events at thawing or at infusion of the cells</b>		<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
<i>If Yes, please provide detailed information:</i>			



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<b>ENGRAFTMENT</b>	<b>NEUTROPHIL</b> (>500 neutrophils per µl achieved)	<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
	<b>PLATELET</b> (>20000 platelets per µl achieved)	<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
<b>COMPLICATIONS</b>	<b>ACUTE GVHD</b>	<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
	<i>If Yes, please give grade (I, II, III, IV)</i>			
	<i>If Yes, resolved?</i>			
		<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
	<b>CHRONIC GVHD</b>		<input type="checkbox"/>	Yes
			<input type="checkbox"/>	No
			<input type="checkbox"/>	Limited
			<input type="checkbox"/>	Extended
		<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
<b>DONOR CHIMERISM</b>	<i>First CBU</i>	D42		
		D100		
		D360		
	<i>Second CBU</i>	D42		
		D100		
		D360		
<b>RECURRENCE of the original disease:</b>		<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
<b>REJECTION or graft failure:</b>		<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
<i>If Yes, please give date:</i>				
<b>Has the recipient been re-transplanted:</b>		<input type="checkbox"/>	Yes	
		<input type="checkbox"/>	No	
<i>If Yes, please give source of stem cells:</i>				
<b>Comments:</b>				
<b>Name of person completing the form:</b>				
<b>Date:</b>				