

UKALL14 'Registration only' - Transplant to D100 Form (1/2)

Transplant & Conditioning

Complete within 30 days of Day 100 visit

Indicate what treatment the patient received between end of induction and beginning of transplant conditioning (1=Yes, 2-No):

None		
Intensification / Delayed Intensification		
Consolidation		If yes, No. of cycles (1 - 4): _____
Interim Maintenance (UKALL2011)		
Maintenance (3m cycles)		No. of months: _____

Source of donor cells:

- 1= Sibling
 2= Matched unrelated donor (MUD) 8/8
 3= Mismatched unrelated
 4= Haploidentical
 5= Cord blood
 6= Other, specify: _____

Type of conditioning:

- 1= Myeloblastic
 2= Non-myeloblastic

Date conditioning started (dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Transplant D0 (dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Conditioning drugs given (1=Yes, 2=No):

Etoposide	<input type="text"/>
Cyclophosphamide	<input type="text"/>
Fludarabine	<input type="text"/>
Melphalan	<input type="text"/>
Alemtuzumab	<input type="text"/>
Busulphan	<input type="text"/>
Other, specify _____	<input type="text"/>

Did patient receive TBI (1=yes, 2=no)

If yes, total dose (cGy):

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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No. of fractions:

<input type="text"/>	<input type="text"/>
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UKALL14 'Registration only' - Transplant to D100 Form (2/2)

Day 100 Post Transplant Assessment

If patient has died prior to Day 100, please submit a Death Form (and a Relapse Form as applicable)

Date of Day 100 Assessment (dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Patient status

Remission Status (1=CR, 2=not in CR)

If not in CR, please submit a relapse form

Graft versus Host Disease

Has the patient experienced GvHD? (1=Yes, 2=No)

If yes, please complete a GvHD form.

Complications of Transplant

Did patient experience Venous-occlusive disease (VOD) during admission?
(1=Yes, 2=No)

Engraftment

Neutrophil count of $0.5 \times 10^9/L$ reached?
(1=Yes, 2=No, 3=Never below this level)

If Yes, please specify date:

Date Neutrophil count reached $0.5 \times 10^9/L$

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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If No, complete below fields

Graft Failure

Date graft failure confirmed
(dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Number of days post
transplant

Please indicate the type of graft failure
(1=Primary, 2=Secondary)

Date **primary** engraftment achieved
(dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Date **secondary** graft failure recorded
(dd/mm/yyyy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Next form: Annual Follow Up (Due 1 year after Transplant Day 0)

Completed
by:

Signature:

Date
completed:

d	d	m	m	y	y	y	y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>