Patient Name / ID Nr. |______________________________|

Date of Birth (dd/mm/yy) |__|__||__|__||__|__|

Examination ☐ day 120 (mm/yyyy) |__|__||__|__|__|__|

☐ day 180 (mm/yyyy) |__|__||__|__|__|__|

Immunosuppressive Therapy

Cyclosporin A ongoing ☐ no ☐ yes
if no, protocol violation, rational I______________________________|

Complications since Last Report

Infection ☐ no ☐ yes CTCAE grade

	CTCAE grade	
☐ bacterial	☐ 3 ☐ 4	organism if known I____________________I
☐ fungal	☐ 3 ☐ 4	organism if known I____________________I
☐ parasitic	☐ 3 ☐ 4	organism if known I____________________I
☐ viral	☐ 3 ☐ 4	organism if known I____________________I
☐ unknown	☐ 3 ☐ 4	organism if known I____________________I

EBV PCR performed ☐ no ☐ yes, I_______I ☐ copies / ml PB , date

☐ copies / 10^5 PB-MNC

Date(dd/mm/yy) |__|__||__|__||__|__|

EBV LPD ☐ no

☐ yes, Date(dd/mm/yy) |__|__||__|__||__|__|

Symptoms:

fever	☐ no	☐ yes
malaise	☐ no	☐ yes
weight loss	☐ no	☐ yes

Site:

mediastinal lymph nodes	☐ no	☐ yes
abdominal lymph nodes	☐ no	☐ yes
inguinal lymph nodes	☐ no	☐ yes
axillary lymph nodes	☐ no	☐ yes
cervical lymph nodes	☐ no	☐ yes
gut	☐ no	☐ yes
lung	☐ no	☐ yes
tonsils	☐ no	☐ yes
other	☐ no	☐ yes, specify

I____________________I

Treatment:

anti CD20 antibodies	☐ no	☐ yes	steroids	☐ no	☐ yes
virustatic therapy	☐ no	☐ yes	reduction of IST	☐ no	☐ yes
chemotherapy	☐ no	☐ yes	stop of IST	☐ no	☐ yes

other I____________________I

			CTCAE grade	
Hemorrhage	☐ no	☐ yes	☐ 3 ☐ 4	
Renal/Metabolic Lab., Creatinine	☐ no	☐ yes	☐ 3 ☐ 4	CTCAE
Other	☐ no	☐ yes	I___________________________I	Grade ☐ 3 ☐ 4
			I___________________________I	Grade ☐ 3 ☐ 4

Response

Transfusions

Still transfusion dependent on red cells ☐ no ☐ yes date of last transfusion |__|__||__|__||__|__|

Still transfusion dependent on platelets ☐ no ☐ yes date of last transfusion |__|__||__|__||__|__|

Granulocyte transfusion ☐ no ☐ yes

Complete blood count (mandatory): |__|__||__|__||__|__| (dd/mm/yy)

RBC(Ery) _______ unit ______ WBC _______ unit ______

MCV _______ unit ______ ANC _______ unit ______

Hb _______ unit ______ Platelets _______ unit ______

Reti _______ unit ______

Hematology (Reference Morphology) date (dd/mm/yy): |__|__||__|__||__|__|

RBC (Ery) _______ unit ______
MCV _______ unit ______
Hb _______ unit ______
Reti _______ unit ______
WBC _______ unit ______
ANC _______ unit ______
Platelets _______ unit ______

Bone marrow aspirate

Cell content □ decreased □ normal □ increased

Megakaryocytes □ decreased □ normal □ increased □ none

Differential count (%)	**Peripheral blood**	**Bone marrow**
Blast		
Promyelocyte		
Myelocyte		
Metamyelocyte		
Band		
Segmented		
Eosinophil		
Basophil		
Lymphocyte		
Monocyte		
Erythroblast		
	100	**100**
Name of review.center		

Karyotype performed ☐ no ☐ yes if yes, please enclose copy of report

Response: ☐ Complete response according to Def. A date(dd/mm/yy) I__I__II__I__II__I__I
(ANC ≥ 1.5 x 10^9/l, Hb ≥ age adjusted cut-off value, Plt ≥150 x 10^9/l)

according to Def. B date(dd/mm/yy) I__I__II__I__II__I__I
(ANC ≥ 1.5 x 10^9/l, Hb ≥ age adjusted cut-off value, Plt ≥100 x 10^9/l)

☐ Partial response date(dd/mm/yy) I__I__II__I__II__I__I
(no Plt or RBC transfusion, ANC ≥ 0.5 x 10^9/l, self sustained Hb ≥ 6.0 g/dl, Plt ≥ 20 x 10^9/l)

☐ Non response (neither PR or CR)

☐ Progress to MDS/AML/aberrant karyotype date(dd/mm/yy) I__I__II__I__II__I__I

☐ Relapse date(dd/mm/yy) I__I__II__I__II__I__I

☐ PNH disease date(dd/mm/yy) I__I__II__I__II__I__I

Following Therapy SCT ☐ no ☐ yes (please complete the EWOG MDS transplant form)

Other ☐ no ☐ yes please specify I________________________________I

Status

☐ Alive Performance status Karnofsky/ Lansky I______I %

☐ Dead if yes: date of death (dd/mm/yy) I__I__II__I__II__I__I

Autopsy ☐ no ☐ yes

Main cause of death ☐ hemorrhage

☐ infection

☐ other I________________________________I

Date I__I__II__I__II__I__I Signature ________________________________