

- liver 1 2 3
- joints and fascia 1 2 3
- genital tract 1 2 3
- performance score 1 2 3
- other, specify | _____ |

maximum (overall) grade mild moderate severe

- Treatment of cGvHD** no yes
- CSA dose(mg/kg/day)|____| for |____| days
 - Prednison dose(mg/kg/day)|____| for |____| days
 - MMF dose(mg/kg/day)|____| for |____| days
 - ECP Starting date |__|_|_|_|_|_|_|_|_| (dd/mm/yyyy)
Last date |__|_|_|_|_|_|_|_|_| (dd/mm/yyyy)
 - Other drug specify | _____ |

Severe Complications

Infections	date	localisation		pathogen, please specify
		systemic	localized	
bacterial	__ _ _ _ _ _ _ _ _ (dd/mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	_____
fungal	__ _ _ _ _ _ _ _ _ (dd/mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	_____
parasitic	__ _ _ _ _ _ _ _ _ (dd/mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	_____
viral	__ _ _ _ _ _ _ _ _ (dd/mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> CMV infection <input type="checkbox"/> CMV disease			
	<input type="checkbox"/> EBV infection <input type="checkbox"/> EBV PTLD			
	<input type="checkbox"/> other, please specify _____			

Pulmonary toxicity no yes

Radiologic changes and/or oxygen support no yes

Mechanical ventilation no yes

Severe cardio-vascular complications no yes

Shortening fraction < 25% no yes

Inotropic support with catecholamines no yes

Anti-arrhythmic therapy no yes

Severe renal complications no yes

Relevant creatinine elevation > CTCAE grade 2 no yes
(CTCAE grade 3: > 3.0 - 6.0 x ULN, CTCAE grade 4: > 6.0 x ULN, CTCAE grades 1 and 2 are treated as not relevant)

Hemodialysis or hemofiltration no yes

Fanconi syndrome no yes
(Renal Fanconi syndrome: glucosuria, aminoaciduria, phosphaturia and/or tubular acidosis)

Nephrotic syndrome no yes
(Nephrotic syndrome: hyperlipidemia, proteinuria, edema)

Severe hepatic complications no yes

Relevant bilirubin elevation > CTCAE grade 2

 no yes

(CTCAE grade 3: > 3.0 - 10.0 x ULN, CTCAE grade 4: > 10.0 x ULN, CTCAE grades 1 and 2 are treated as not relevant)

Hemosiderosis

 no yes

Ferritin (Serum) | _____ | (µg/l)

Date |__|_|_||||__|_|_||||__|_|_|_|_|_| (dd/mm/yyyy)

SQUID | ____ | mg / g liver-dry weight

Date |__|_|_||||__|_|_||||__|_|_|_|_|_| (dd/mm/yyyy)

Liver-biopsy | ____ | mg / g liver-dry weight Date |__|_|_||||__|_|_||||__|_|_|_|_|_| (dd/mm/yyyy)

Iron-MRI performed

 no yes, please enclose reportTherapy: no yes chelation Other, please specify | _____ |**Severe neurological complications** no yes

Leukoencephalopathy (Only if positive in MRI finding)

 no yes

CNS haemorrhage

 no yes

Seizures

 no yes**Severe gastrointestinal complications** no yes

Ileus

 no yes**Endocrinology** no yes

Hypothyroidism

 no yes, Substitution no yes

Pancreatic insufficiency

 no yes, Substitution no yes

Diabetes mellitus

 no yes, Substitution no yes

Growth hormone deficiency

 no yes, Substitution no yes

Hypogonadism

 no yes, Substitution no yes

Adrenal insufficiency

 no yes, Substitution no yes

Panhypopituitarism

 no yes, Substitution no yes

Cushing

 no yes

other

 no yes, Therapy no yes**Visual disorder** no yes

Cataract

 no yes

other

 no yes, please specify | _____ |**Hearing disorder** no yes, please specify | _____ |**Muscles/ bones** no yes

Osteopathy

 no yes, Therapy no yes

Chronic muscle pain

 no yes, Therapy no yes

Fractures

 no yes, please specify | _____ |

Joint pain

 no yes, Therapy no yes

Connective tissue disease (ANA-screening)

 no yes

Complement diagnostics

 no yes if abnormal, please send report

Osteodensitometry testing

 no yes normal

abnormal, please send report

Other no yes, please specify |_____|

Immunological parameters analysed no yes

Phenotyping of lymphocyte subpopulation no yes if abnormal, please send report

Immunoglobulin G levels normal decreased

Other abnormalities no yes please send report

Other severe complications no yes, please specify |_____|
|_____|

Graft failure

Graft failure occurred no yes,
 rejection
 late loss of graft
date |_|_|||_|_|||_|_|_|_|_| (dd/mm/yyyy)

Status

Disease status:

CR Autologous reconstitution Secondary malignancy, specify |_____|
date of diagnosis |_|_|||_|_|||_|_|_|_|_| (dd/mm/yyyy)

Survival status:

Alive, date of last examination |_|_|||_|_|||_|_|_|_|_| (dd/mm/yyyy) Karnofsky/ Lansky score |_____| %

Dead, date of death |_|_|||_|_|||_|_|_|_|_| (dd/mm/yyyy) Autopsy no yes

Cause of death: (check as many as appropriate)

	no	yes
<input type="checkbox"/> Rejection / poor graft function	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GvHD	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Veno-Occlusive disease (VOD)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EBV lymphoprolif. disease (LPD)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pulmonary toxicity	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Liver failure	<input type="checkbox"/>	<input type="checkbox"/>

Other, specify _____

Further comments: _____

Date: |_|_|||_|_|||_|_|_|_|_| Stamp

Signature _____