"The First Gift"
The St. Louis Cord Blood Bank

POST-TRANSPLANT RECORD (6-12 months)

Patient's Name: _____ SLCBBB ID: _____
Transplant Center: _____ Transplant Physician: _____
F/U Physician: _____ Medical Center: _____

1. Patient's current status:

Alive ☐ yes ☐ No

Date of Death: _____ (Month-day-year) Autopsy ☐ yes ☐ no

Cause of Death: _____

Relapse or Recurrence Of Disease ☐ yes ☐ no Date: _____ (Month-day-year)

2. **Engraftment/Hematologic evaluation** (most recent) date: _____ (Month-day-year)

a) CBC

WBC: _____ ANC: _____ Plts: _____ Hct/Hb: _____

ABO Type: _____ Rh: _____

Plts > 20,000/μ L ☐ yes ☐ no Date: _____

Plts > 50,00/μ L ☐ yes ☐ no Date: _____

b) Transfusions ☐ yes ☐ no

Platelets ☐ yes ☐ no If no, date of last transfusion: _____

PRBCs ☐ yes ☐ no If no, date of last transfusion: _____

c) Chimerism studies performed at your Center ☐ Yes ☐ No

Most recent, Date: _____ **Method:** _____

Peripheral blood _____ % donor **Bone marrow** _____ % donor

d) Secondary Graft Failure ☐ Yes ☐ No Date : _____

e) New or persistent hematologic problems ☐ Yes ☐ No

If yes, describe: _____

Suspected etiology? _____

f) Need for temporary growth factor support ☐ Yes ☐ No

Agent: _____ Date started: _____ Date stopped: _____

g) Did the patient receive other stem cell transplant after the STLCBB's Unit?

☐ yes ☐ No **If yes,** date: _____ (Month-day-year)

If yes, type:
- ☐ Autologous BM
- ☐ Related BM
- ☐ Unrelated BM
- ☐ Related PCB
- ☐ Autologous PBSC
- ☐ Related PBSC
- ☐ Unrelated PBSC
- ☐ Unrelated PCB unit

(BM: bone marrow, PBSC: peripheral blood stem cells, PCB: placental/cord blood)

If yes, reason: _____

3. **Immune reconstitution** ☐ complete ☐ partial

Immunoglobulin levels	☐ Normal	☐ Low	Date:	_____
PhA stimulation	☐ Normal	☐ Decreased	Date:	_____
NK cells	☐ Normal	☐ Decreased	Date:	_____
T-cells/subsets	☐ Normal	☐ Decreased	Date:	_____
B-cells/subsets	☐ Normal	☐ Decreased	Date:	_____
Other: _____			Date:	_____

Immunizations re-instituted: ☐ yes ☐ no Date: _____

Patient's Name: _____ SLCBB ID: _____

4. Chronic GvHD:

a) Evidence of chronic GvHD: ☐ Yes ☐ No Date of dx: _____

Site: ☐ Skin ☐ Limited ☐ extensive
☐ Gut
☐ Liver

Other organ involvement: _____

Biopsy for GvHD ☐ Yes ☐ No Site: _____
Pathology consistent with GvHD ☐ yes ☐ no

GvHD treatment

Agent: _____ Date started: _____ Date stopped: _____
Agent: _____ Date started: _____ Date stopped: _____

Response ☐ None ☐ Improved ☐ Resolved

5. Infections (6-12 months after transplant)

a) Bacterial Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____

b) Viral Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____

c) Fungal Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____
Site: _____ Organism: _____ Date of dx: _____

d) Parasitic: Site: _____ Organism: _____ Date of dx: _____

6. Non-Infectious complications (6-12 months after transplant):

a) Pulmonary ☐ Yes ☐ No

☐ Interstitial pneumonia ☐ Bronchiolitis obliterans
☐ Restrictive airway disease ☐ Pulmonary edema
☐ Obstructive airway disease ☐ Other: _____

b) Cardiac ☐ Yes ☐ No

☐ Cardiomyopathy
☐ Congestive heart failure ☐ Other: _____

c) Renal ☐ Yes ☐ No

☐ Nephritis
☐ Renal failure ☐ Other: _____

d) GI ☐ Yes ☐ No

☐ Liver Dysfunction ☐ Other: _____

f) Endocrine ☐ Yes ☐ No

☐ Thyroid ☐ Adrenal
☐ Gonadal ☐ Other: _____
☐ Pituitary Describe: _____

Patient's Name: _____ SLCBB ID: _____

7. Other treatments/prophylaxis

PCP prophylaxis	☐	Yes	☐	No	Agent: _____	Duration of tx:	_____
Fungal prophylaxis	☐	Yes	☐	No	Agent: _____	Duration of tx:	_____
Antiviral agents	☐	Yes	☐	No	Agent: _____	Duration of tx:	_____
IVIG	☐	Yes	☐	No	Frequency of Tx: _____		

Other: _____

8. Development of other disease or second malignancy:

☐ no ☐ no Specify: _____

9. Evaluation of primary disease (other than malignancy)

_____

_____

10. Additional Comments:

_____

_____

Form completed by:

_____ (print) Date: _____
month-day-year

_____ (signature) Tel: _____

Fax: _____