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

POST-TRANSPLANT RECORD (3-6 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 ☐ Autologous PBSC
☐ Related BM ☐ Related PBSC
☐ Unrelated BM ☐ Unrelated PBSC
☐ Related PCB ☐ 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: __________

Patient's Name: ______________________ SLCBB ID: ____________

4. Graft versus Host Disease:

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

b) If no GvHD present, is the patient currently receiving GvHD prophylaxis?:

☐ yes ☐ no ☐ Steroids

☐ Cyclosporine

☐ Other: ______________________

5. Infections (3-6 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 (3-6 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

☐ Pericardial effusion ☐ Other: ____________

c) Renal ☐ Yes ☐ No

☐ Nephritis

☐ Renal failure ☐ Other: ____________

d) GI ☐ Yes ☐ No

☐ Liver Dysfunction ☐ Other: ____________

f) Endocrine ☐ Yes ☐ No

☐ Thyroid ☐ Adrenal

☐ Gonadal
☐ Pituitary
☐ Other: ______________________

7. Other treatments/prophylaxis

PCP prophylaxis	☐ Yes	☐ No	Agent:	______________
Fungal prophylaxis	☐ Yes	☐ No	Agent:	______________
Antiviral agents	☐ Yes	☐ No	Agent:	______________
IVIG	☐ Yes	☐ No	Frequency of Tx:	______________

Other: ______________________

8. Evaluation of primary disease (other than malignancy)

____

____

9. Additional Comments:

____

____

Form completed by:

______________________ (print) Date: ______________
month-day-year

______________________ (signature) Tel: ______________

Fax: ______________