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

TRANSPLANT RECORD

Patient's Name: _____ SLCBBB ID: _____
Transplant Center: _____
Transplant Physician: _____

1. Patient's History

a) **Primary Diagnosis:** _____ Date of Diagnosis: _____ (Month-day-year)

Cytogenetic abnormalities (if any): _____

b) **Treatment PRIOR to cytoreduction and placental cord blood transplant:**

Chemotherapy: ☐ yes ☐ no If yes, agents: _____

Protocol: _____

Radiation: ☐ Yes ☐ No If yes, total dose: _____

Site: ☐ CNS ☐ Mediastinum ☐ Testes ☐ Other: _____

Transplant: ☐ Yes ☐ no If yes, date: _____ (Month-day-year)

If yes, type: ☐ Autologous BM ☐ Autologous PBSC
BM: Bone Marrow ☐ Related BM ☐ Related PBSC
PBSC: Peripheral blood stem cells ☐ Unrelated BM ☐ Unrelated PBSC
PCB: Placental/cord blood ☐ Related PCB ☐ Unrelated PCB unit

Other Therapies: ☐ ATG ☐ Steroids ☐ Growth Factors: _____
☐ Other: _____

c) **Transfusions:**

PRBCs	☐ Yes	☐ No	☐ Dependent
Platelets	☐ yes	☐ No	☐ Dependent

d) **Infectious disease testing (most recent):** (ND: not done)

CMV antibody	☐ Positive	☐ Negative	☐ ND
EBV antibody	☐ Positive	☐ Negative	☐ ND
Toxoplasma antibody	☐ Positive	☐ Negative	☐ ND
VZV Antibody	☐ Positive	☐ Negative	☐ ND
Hepatitis B surface antigen	☐ Positive	☐ Negative	☐ ND
Hepatitis C antibody	☐ Positive	☐ Negative	☐ ND
Herpes Simplex antibody	☐ Positive	☐ Negative	☐ ND
HIV antibody	☐ Positive	☐ Negative	☐ ND

e) **Patient's blood type PRIOR to placental cord blood transplant:**

ABO Type: _____ RH: _____

2. Patient's evaluation PRIOR to placental cord blood transplant (most recent):

a) **Malignant disease**

☐ **Complete remission** ☐ 1st ☐ 2nd ☐ 3rd or greater
If other than **CR1**, date(s) of relapse: _____
Sites(s): _____

☐ **Relapse** ☐ 1st ☐ 2nd ☐ 3rd or greater
Site(s): _____
Date of Relapse: _____ (Month-day-year)

☐ **No response to treatment/progressive disease**

For **CML**
Chronic phase ☐ 1st ☐ 2nd or greater
Accelerated phase ☐ 1st ☐ 2nd or greater
Blastic crisis ☐ 1st ☐ 2nd or greater

Patient's Name: _____ **SLCBB ID:** _____

b) **Non-malignant condition**
- ☐ Progressive disease
- ☐ No response to other therapies
- ☐ Complications/organ involvement

Describe: _____

c) **Wt: _____ kg**

d) **Fever >38.5° in past 2 weeks** ☐ Yes ☐ No Days: _____

Infection in past 2 weeks Prior to transplant ☐ Yes ☐ No

Site: _____ Organism: _____

Site: _____ Organism: _____

Antibiotics: ☐ Yes ☐ No

e) **Liver function** ☐ nl ☐ abnormal (specify: _____)

f) **Renal function** ☐ nl ☐ abnormal (specify: _____)

g) **Cardiac function** ☐ nl ☐ abnormal (specify: _____)

h) **CNS status** ☐ nl ☐ abnormal (specify: _____)

3. Cytoreduction regimen for placental cord blood transplant:

a) **Total Body Irradiation** ☐ Yes ☐ No

Other radiation regimen Describe: _____

fractionated ☐ ☐ No

Total dose: _____

b) **Chemotherapy**
- ☐ Cyclophosphamide Dose: _____
- ☐ Etoposide Dose: _____
- ☐ Thiotepa Dose: _____
- ☐ Busulfan Dose: _____
- ☐ Melphalan Dose: _____
- ☐ Cytarabine Dose: _____
- ☐ ATG Dose: _____
- ☐ Other _____

4. Placental cord blood Transplant/PCB unit:

a) **Date of transplant:** _____ **Month-day-year**

b) **Volume infused:** _____

c) **Thawing procedure:** ☐ SLCBB ☐ Other Describe: _____

Any other manipulations of the unit prior to infusion? ☐ Yes ☐ No

Specify: _____

Problems during thaw procedure? ☐ yes ☐ no

Describe: _____

d) **Post-thaw tests of the PCB unit:**

Cells Viability: _____ % Method: _____

Total WBC _____

CD34+ _____ (% 0f total cells) Method: _____

Clonogenic assays ☐ Yes ☐ No

Type of assay: _____

Results: _____

Bacterial cultures ☐ Yes ☐ No

If yes, ☐ Positive ☐ Negative

Patient's Name: _____ **SLCBB ID:** _____

Organism: _____

Patient's Name: _____ **SLCBB ID:** _____

e) **Any serious adverse reactions during post infusion?** ☐ Yes ☐ No

List reactions requiring interventions, e.g. O_2 administration, blood pressure support, bronchodilators, need to diuretics > 6h after transplant)

☐	Bradycardia	☐	Dyspnea, respiratory decompensation
☐	Hypotension	☐	Hemolytic reaction
☐	Anaphylaxis	☐	Acute renal failure
☐	Hypertension	☐	Cardio-respiratory arrest

Form completed by:

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

_____ (signature) Tel: _____

Fax: _____