PATIENT IDENTIFICATION

Hospital: AID:

UPN: DOB: __/__/__

Name ID: Infusion date: __/__/__

Follow up: 30 day | 100 day | 6mth| 1yr | 2 yr | >2yr, specify ___

1.BEST RESPONSE TO HCT OR CELL THERAPY

Include response to maintenance, consolidation and persistent disease therapy. Do not include response to therapy for relapsed/persistent/ progressive disease

Best response to HCT/CT by CT (radiographic) criteria:
- ☐ Continued CR
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ No response / Stable disease (NR/SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

Date best response: __/__/__
- ☐ Previously reported

Best response to HCT/CT by PET (metabolic) criteria:
- ☐ Continued CR
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ No response / Stable disease (NR/SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

Date best response: __/__/__
- ☐ Previously reported

MRD assessed at time of best response: Y | N

If yes, complete table

	BM|Blood| specify other	Pos|Neg|ND	Date sample
Flow cytometry			__/__/__
PCR			__/__/__
NGS			__/__/__

Pathology report(s) submitted: Y | N

2. POST INFUSION THERAPY

Include maintenance, consolidation, and persistent disease therapy. Do not include therapy for relapsed/persistent/ progressive disease

Therapy was given since last report: Y | N

If yes, complete the following

Systemic therapy: Y | N

If yes, date maintenance therapy started: __/__/__
- ☐ previously reported
- ☐ NA, continued from previous period
- ☐ unknown

date stopped: __/__/__
- ☐ previously reported
- ☐ NA, still continuing
- ☐ unknown

Specify systemic agents:

Reason systemic therapy stopped:
- ☐ Relapse / progression
- ☐ Did not tolerate therapy
- ☐ Considered completed
- ☐ Other: _____
- ☐ Unknown

Therapy part of clinical trial: Y | N | Unk

Clinical Trial ID:

Radiation therapy: Y | N

Cell therapy: Y | N   *if yes complete CT Form*

Other therapy, specify:

Complete this section as many times as required for multiple lines of therapy

3. DISEASE RELAPSE OR PROGRESSION SINCE LAST REPORT

Complete this section if relapsed, or persistent or minimal residual disease present

Relapse/ progression occurred since last report Y | N |Unk

If yes, disease was detected by the following methods:

	Date sample	Disease detected
Molecular eg PCR	__/__/__	Y | N | ND
Cytogenetic: 　FISH 　Karyotyping	__/__/__ __/__/__	Y | N | ND Y | N | ND
Radiological (PET, MRI, CT)	__/__/__	Y | N | ND
Clinical or Haematologic	__/__/__	Y | N | ND

Nodal involvement: Y | N |Unk

Extranodal involvement: Y | N |Unk
specify sites:

Confirmed by biopsy: Y | N | unk

Biopsy report submitted: Y| N

4. THERAPY FOR RELAPSE OR PROGRESSION

Therapy given for relapsed, progressive or minimal residual disease since last report: Y | N

If yes, reason therapy given:
- ☐ Relapsed disease
- ☐ Progressive disease
- ☐ Minimal residual disease

Systemic therapy: Y | N

    If yes, date therapy started: __/__/__
- ❏ previously reported
- ❏ NA, continued from previous period
- ❏ unknown

    date stopped: __/__/__
- ❏ previously reported
- ❏ NA, still continuing
- ❏ unknown

    Specify systemic agents:

    Therapy part of clinical trial: Y | N | Unk

    Clinical Trial ID:

Intrathecal therapy: Y | N

    If yes, date therapy started: __/__/__
- ❏ previously reported
- ❏ NA, continued from previous period
- ❏ Unknown

    date stopped: __/__/__
- ❏ previously reported
- ❏ NA, continued from previous period
- ❏ Unknown

    specify therapy:_____

Intraocular therapy: Y | N

    If yes, date therapy started: __/__/__
- ❏ previously reported
- ❏ NA, continued from previous period
- ❏ Unknown

    date stopped: __/__/__
- ❏ previously reported
- ❏ NA, continued from previous period
- ❏ Unknown

    specify therapy:_____

Radiation therapy: Y | N

Cell therapy: Y | N *if yes complete CT Form*

Other therapy, specify:

Best response to line of therapy by CT (radiographic) criteria:
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ Stable disease (SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

    Date assessed: __/__/__

Best response to line of therapy by PET (metabolic) criteria:
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ Stable disease (SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

    Date assessed: __/__/__

Complete this section as many times as required for multiple lines of therapy

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5. DISEASE STATUS AT THE TIME OF EVALUATION FOR THIS REPORTING PERIOD

Current disease status by CT (radiographic) criteria
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ No response / Stable disease (NR/SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

    Date assessed: __/__/__

Current disease status by PET (metabolic) criteria
- ☐ Complete remission (CR)
- ☐ Partial remission (PR)
- ☐ No response / Stable disease (NR/SD)
- ☐ Progressive disease (PD)
- ☐ Not assessed

    Date assessed: __/__/__

    Deauville score: _____   (12 months post infusion only)