BABY HUG FOLLOW-UP STUDY

STEM CELL TRANSPLANT REPORT

PART I: IDENTIFYING INFORMATION

1. Patient's ID Number: [ ][ ][ ][ ]   2. Current Clinic: [ ][ ]

3. Patient's Letter Code: [ ][ ][ ]

4. Visit Date: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]
   Month - Day - Year

PART II: TRANSPLANT INFORMATION

1. Date of Transplant: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]
   Month - Day - Year

2. Location of Transplant Center

   ____

3. Reason for Transplant in Sickle Cell Disease

Stroke	(1)
Recurrent Acute Chest Syndrome	(2)
Recurrent Painful Episodes	(3)
Other Sickle Cell Related Cause	(4)*
Other NON Sickle Cell Related Cause	(5)*

   *a. Specify ______________________________

ID Number [ ][ ][ ][ ]   Visit [ ][ ][ ] - Seq [ ][ ]

4. Type of Graft:

HLA Matched Sibling Bone Marrow	(1)
HLA Matched Sibling Umbilical Cord Blood	(2)
Matched Unrelated Donor	(3)*
Matched Unrelated Umbilical Cord Blood	(4)*
Haplo-Identical Parent*	(5)*

*a. For non-sibling donor, please indicate degree of matching:

6/6	(1)
8/8	(2)
5/6 5-6-7/8	(3)

PART III: TRANSPLANT COMPLICATIONS

1. What is the patient's current status with respect to their transplant? Answer all that apply.

A. Death Date ___ Month ___ Day ___ Year

B. Graft Rejection Date ___ Month - ___ Day - ___ Year

C. Stable Mixed Chimerism ___ Month - ___ Day - ___ Year

D. Cured of Sickle Cell Disease Date ___ Month - ___ Day - ___ Year

E. Other (1)

i. If other, please specify: ______________________

ii. Date: ___ Month - ___ Day - ___ Year

^ COMPLETE FORM 25 – SERIOUS ADVERSE EVENT

ID Number ____ Visit ____ - Seq ____

PART IV: COORDINATOR

1. Checked for completeness and accuracy:

   A. Certification number: ☐☐ - ☐☐

   B. Signature: ________________________________

   C. General Comments: ________________________________

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