ศูนย์บริการโลหิตแห่งชาติ
สภากาชาดไทย

Patient Progress Report

This form must be e-mailed to the TSCDR Search coordination E-mail: tscdr.coordinators@redcross.or.th

Date (DD -MM- YYYY)_____ ☐ 100 Days *(Only answer section B)*	☐ 30 Days *(answer section A and B)* ☐ __ year *(Only answer section B)* after stem cell transplantation

Patient/Donor Data

Patient name:	Patient ID: (assigned by patient registry)	
Patient Disease:	Patient registry:	Transplant center:
Date of birth : (DD -MM- YYYY)	Date of transplant (DD -MM- YYYY):	Date of last contact: (DD -MM- YYYY):
GRID:	Donor ID:	Donor Registry:

Section A *(answer at 30 days only)*

Was the full stem cell product used at once for transplantation? ☐No ☐ Yes, specify infusion date :
If no, was any portion of the stem cell product stored for later infusion in the same patient? ☐No ☐Yes, amount stored :
If yes, was this portion later infused into the patient? ☐No ☐ Yes, specify infusion date :
If no, please specify the purpose of using stem cell :
Was any unused portion of the stem cell product discarded? ☐No ☐Yes, specify infusion date :

Section B

● Is the recipient alive? ☐No ☐Yes	
Did the stem cells engraft? ☐ N/A ☐ No ☐ Yes, please specify ❍Complete ❍Partial date engraftment:	
Rejection or graft failure? ☐No ☐Yes	If yes, please specify date: (DD -MM- YYYY)
Acute GvHD: ☐No ☐Yes, please grade❍Mild ❍Moderate ❍Severe	If yes, please specify date: (DD -MM- YYYY)
Chronic GvHD: ☐No ☐Yes, please grade❍Mild ❍Moderate ❍Severe	If yes, please specify date: (DD -MM- YYYY)
Infections: ☐No ☐Yes please specify :	
Recurrence of original disease? ☐No ☐Yes	If yes, please specify date: (DD -MM- YYYY)
Has recipient been: Re-transplanted? ☐No ☐Yes Given lymphocyte infusions? ☐No ☐Yes If yes to either, source of stem cells/lymphocytes:	
Karnofsky/Landsky score:	
● If not, date of death (DD -MM- YYYY) :	
Primary cause of death: ☐GvHD ☐Disease relapse/progression ☐Infection ☐Rejection/Poor graft function ☐Pulmonary toxicity ☐VOD ☐Secondary malignancy ☐ Other_____	
Additional comments /complications:	

Transplant center representative:	Date (DD -MM- YYYY):	Signature: