

**FOLLOW-UP: INSERT I**  
**Acute Myelogenous Leukemia**

**FOR REGISTRY USE ONLY:**  
 I.D. **L** - [ ] [ ] [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ]  
 Date received:

TEAM [ ] [ ] [ ] [ ] IUBMID [ ] [ ] [ ] [ ] [ ] [ ]  
 (Institutional Unique Blood or Marrow Transplant Identification Number)

Registry: **IBMTR** **ABMTR** (circle one)

Date of transplant for which this form is being completed: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Month Day Year

Date of report: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 Month Day Year

**Follow-up Information**

**\* Report data for date of last contact as reported in Q.3 of Follow-up Core Form or immediately prior to death.**

1. Was treatment given posttransplant to prevent recurrence of AML since date of last report?

- 1  Yes  
 0  No

Specify treatment:  
 Yes No

2. 1  0  Intrathecal drugs, specify: \_\_\_\_\_

3. 1  0  CNS irradiation

4. 1  0  Immune therapy

Specify:  
 Yes No

5. 1  0  Interleukin-2 (IL-2)

6. 1  0  Interferon-alpha

7. 1  0  Interferon-gamma

8. 1  0  Linomide

9. 1  0  Other, specify: \_\_\_\_\_

10. 1  0  Other, specify: \_\_\_\_\_

11. Specify status of disease at time of this report or at time of death:

- 1  In continuous complete remission posttransplant
- 2  Therapy-induced complete remission after persistent or recurrent leukemia posttransplant
- 3  Relapse or persistent disease

12. Date of relapse: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  Never in remission  
 Month Day Year

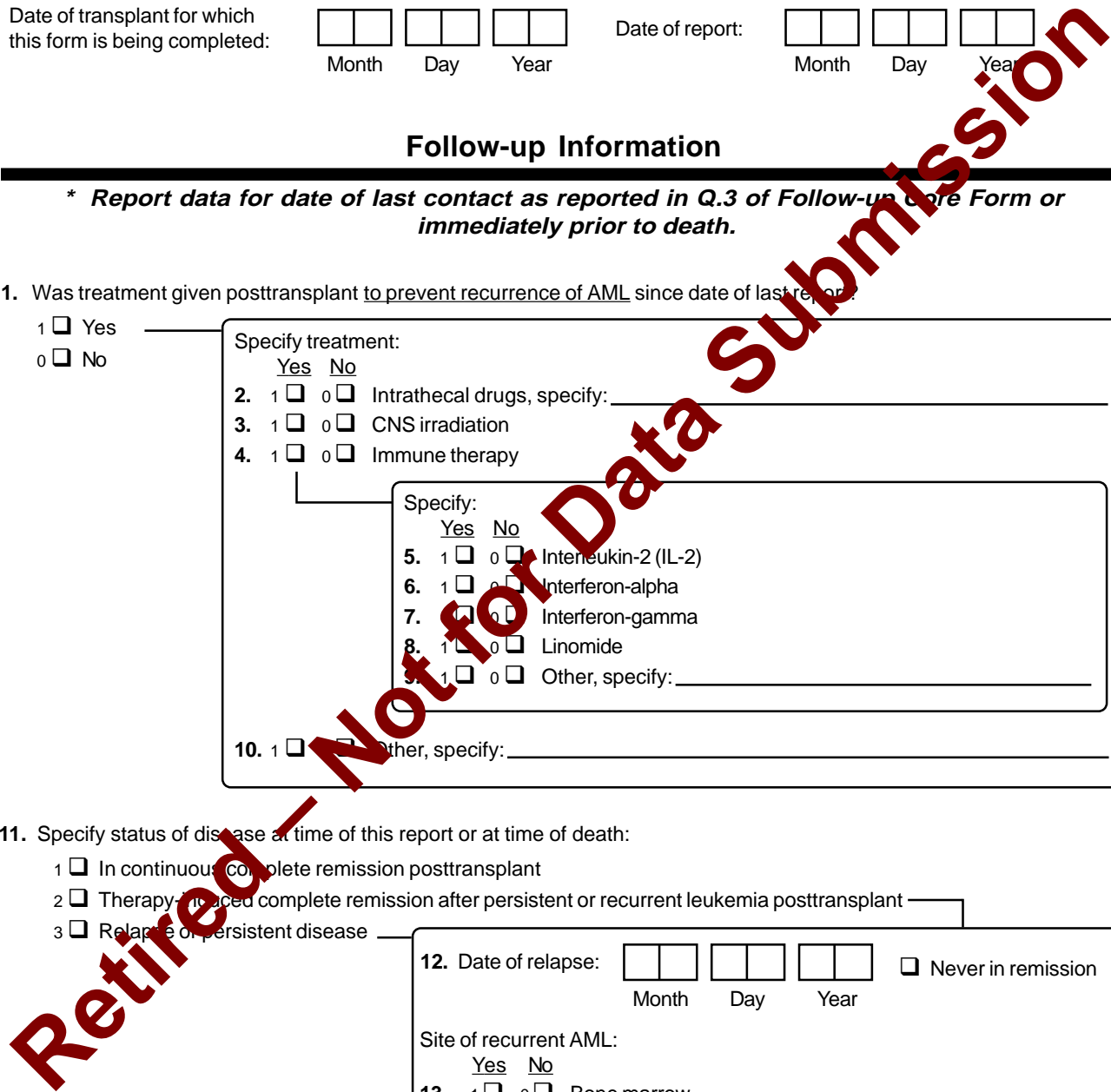
Site of recurrent AML:  
 Yes No

13. 1  0  Bone marrow

14. 1  0  CNS

15. 1  0  Testes

16. 1  0  Other, specify: \_\_\_\_\_



TEAM

IUBMID

17. Was patient treated for posttransplant relapse or persistent disease since date of last report?

- 1  Yes
- 0  No
- 8  Unknown

Specify treatments given:

	Yes	No	
18.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Interferon gamma
19.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Interferon alpha
20.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Chemotherapy
21.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Withdrawal of immune suppression
22.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Immunotoxins
23.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Donor leukocytes
24.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Second transplant
25.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Growth factors, specify: _____
26.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Other, specify: _____
27.	Did the patient achieve complete remission?		
	1 <input type="checkbox"/>	Yes	
	0 <input type="checkbox"/>	No	
	8 <input type="checkbox"/>	Unknown	

Note: If Q.23 or 24 are checked yes, complete a separate report covering the subsequent transplant (see note on page 18 of Core Form regarding infusion of donor leukocytes)

**Retired – Not for Data Submission**