FOLLOW-UP INSERT XXI
Multiple Sclerosis

FOR REGISTRY USE ONLY:
I.D. ☐ – ☐☐☐☐ – ☐☐☐☐☐☐
Date received:

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐
(Institutional Unique Blood or Marrow Transplant Identification Number)

Registry (circle one): IBMTR ABMTR EBMT

Date of transplant for which this form is being completed: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

Date of report: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

Follow-up Information*

**** Report data from date of last contact or immediately prior to death***

1. Date of evaluation for this report: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

2. Did exacerbation or recurrence of Multiple Sclerosis occur since last report?
1 ❑ Yes
0 ❑ No

3. Specify date of first exacerbation of recurrence since last report: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

4. Specify number of relapses since last report: ☐☐ 8 ❑ Unknown

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

5. Did patient receive treatment for multiple sclerosis since last report?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

Reason for Therapy Codes
1 = Planned per protocol
2 = Continued from pretransplant
3 = Relapse/Progression of MS
7 = Other, specify
8 = Unknown

Cite regimens:

	Yes	No	Unk		Reason for Therapy (use codes above)	Start Date Month Day Year	Still Receiving
6.	1❑	0❑	8❑	α-interferon			1❑
7.					☐ If *Other*, specify:		
8.	1❑	0❑	8❑	ß-interferon			1❑
9.					☐ If *Other*, specify:		
10.	1❑	0❑	8❑	Anti-lymphocyte antibodies			1❑
11.					☐ If *Other*, specify:		
12.	1❑	0❑	8❑	Azathioprine			1❑
13.					☐ If *Other*, specify:		
14.	1❑	0❑	8❑	Cop-I			1❑
15.					☐ If *Other*, specify:		
16.	1❑	0❑	8❑	Corticosteroids – chronic low-dose			1❑
17.					☐ If *Other*, specify:		
18.	1❑	0❑	8❑	Corticosteroids – pulse high dose			1❑
19.					☐ If *Other*, specify:		
20.	1❑	0❑	8❑	Craniospinal irradiation			1❑
21.					☐ If *Other*, specify:		
22.	1❑	0❑	8❑	Cyclophosphamide			1❑
23.					☐ If *Other*, specify:		
24.	1❑	0❑	8❑	Lymphocytopheresis			1❑
25.					☐ If *Other*, specify:		
26.	1❑	0❑	8❑	Mitoxantrone			1❑
27.					☐ If *Other*, specify:		
28.	1❑	0❑	8❑	Plasmapheresis			1❑
29.					☐ If *Other*, specify:		
30.	1❑	0❑	8❑	Total lymph node irradiation (TLI)			1❑
31.					☐ If *Other*, specify:		
				Other(s), specify:			
32.	1❑	0❑	8❑	_____			1❑
33.					☐ If *Other*, specify:		

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Disease Status at Current Evaluation

34. Scripps neurological rating scale score: ☐☐☐ ❑ Unknown

Kurtze functional systems scores:

35. Pyramidal ☐☐ ❑ Unknown

36. Cerebellar ☐☐ ❑ Unknown

37. Brain stem ☐☐ ❑ Unknown

38. Sensory ☐☐ ❑ Unknown

39. Bowel/Bladder ☐☐ ❑ Unknown

40. Visual ☐☐ ❑ Unknown

41. Cerebral ☐☐ ❑ Unknown

42. Other functions ☐☐ ❑ Unknown

43. Others, specify: ☐☐ ❑ Unknown

_____

44. Kurtze Expanded Disability Status Scale (EDSS): ☐☐.☐ ❑ Unknown

Composite Scale

Timed 25-foot Walk:

45. Assistive device used? 1❑ Yes 0❑ No ❑ Unknown

46. Specify:
- 1❑ Unilateral assistance (cane or crutch)
- 2❑ Bilateral assistance (canes or crutches)
- 3❑ Walker or similar device

47. Time for Trial 1: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

48. Time for Trial 2: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

9-hole Peg Test:

49. Dominant Hand, Time for Trial 1: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

50. Dominant Hand, Time for Trial 2: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

51. Non-dominant Hand, Time for Trial 1: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

52. Non-dominant Hand, Time for Trial 2: ☐☐☐.☐ sec. 1❑ Did not complete ❑ Unknown

Paced Auditory Serial Addition Test (PASAT):

53. PASAT 3 Score: ☐☐ Range (0-60) ❑ Unknown

54. PASAT 2 Score: ☐☐ Range (0-60) ❑ Unknown

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

55. Date of most recent MRI scan of brain since last report:

☐☐ ☐☐ ☐☐☐☐ Month Day Year

7❑ MRI not done since last report
8❑ Date unknown

MRI scan:

56. Are gadolinium-enhancing lesions present on the MRI? 1❑ Yes 0❑ No 8❑ Unknown

57. Number of gadolinium-enhancing lesions: ☐☐ 8❑ Unknown

58. Are new lesions present on the MRI? 1❑ Yes 0❑ No 8❑ Unknown

58. Indicate new lesions present *(check only one)*
1❑ Gadolinium-enhancing
2❑ Unenhancing
3❑ Both
8❑ Unknown

59. Was there evidence of disease activity present at current evaluation? 1❑ Yes 0❑ No 8❑ Unknown

60. Date of first evidence of disease activity at current evaluation:

☐☐ ☐☐ ☐☐☐☐ Month Day Year 8❑ Unknown