



Blood Sample Collection

Date of sample	<table border="1"> <tr> <td>_ _ _ _ </td> <td>·</td> <td>_ _ _ _ </td> <td>·</td> <td>_ _ _ _ </td> <td>_ _ _ _ </td> </tr> <tr> <td>Day</td> <td></td> <td>Month</td> <td></td> <td>Year</td> <td></td> </tr> </table>	_ _ _ _	·	_ _ _ _	·	_ _ _ _	_ _ _ _	Day		Month		Year	
_ _ _ _	·	_ _ _ _	·	_ _ _ _	_ _ _ _								
Day		Month		Year									

Physician Information

Name	
Affiliation	<input type="checkbox"/> academic <input type="checkbox"/> regional hospital <input type="checkbox"/> office based hematologist
City	
Country	

Patient Information

Initials	<table border="1"> <tr> <td>_ _ _ _ </td> <td>first name / last name</td> </tr> </table>	_ _ _ _	first name / last name										
_ _ _ _	first name / last name												
Date of Birth	<table border="1"> <tr> <td>_ _ _ _ </td> <td>·</td> <td>_ _ _ _ </td> <td>_ _ _ _ </td> </tr> <tr> <td>Month</td> <td></td> <td>Year</td> <td></td> </tr> </table>	_ _ _ _	·	_ _ _ _	_ _ _ _	Month		Year					
_ _ _ _	·	_ _ _ _	_ _ _ _										
Month		Year											
Sex	<input type="checkbox"/> male <input type="checkbox"/> female												
Ethnicity	<input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Oriental/Asian <input type="checkbox"/> Other _____												
Date of informed consent	<table border="1"> <tr> <td>_ _ _ _ </td> <td>·</td> <td>_ _ _ _ </td> <td>·</td> <td>_ _ _ _ </td> <td>_ _ _ _ </td> </tr> <tr> <td>Day</td> <td></td> <td>Month</td> <td></td> <td>Year</td> <td></td> </tr> </table>	_ _ _ _	·	_ _ _ _	·	_ _ _ _	_ _ _ _	Day		Month		Year	
_ _ _ _	·	_ _ _ _	·	_ _ _ _	_ _ _ _								
Day		Month		Year									
Type of BCR-ABL transcript at diagnosis	<input type="checkbox"/> b2a2 (e13a2) <input type="checkbox"/> b3a2 (e14a2) <input type="checkbox"/> b2a2 + b3a2 (e13a2 + e14a2) <input type="checkbox"/> e1a2 <input type="checkbox"/> b2a3 (e13a3) <input type="checkbox"/> b3a3 (e14a3) <input type="checkbox"/> e6a2 <input type="checkbox"/> e19a2 <input type="checkbox"/> unknown <input type="checkbox"/> Other _____												
Eutos Score (at diagnosis)	<input type="checkbox"/> low <input type="checkbox"/> high												
Sokal Score (at diagnosis)	<input type="checkbox"/> low <input type="checkbox"/> intermediate <input type="checkbox"/> high												
Euro (Hasford) Score (at diagnosis)	<input type="checkbox"/> low <input type="checkbox"/> intermediate <input type="checkbox"/> high												



CML Diagnosis, Treatment

CML Diagnosis / / ---
Month Year

First line TKI **Start:** / / ---
Month Year **Stop:** / / ---
Month Year
 unknown unknown ongoing
Treatment: Imatinib **Dose** _____ mg/day
 Nilotinib
 Dasatinib
 Bosutinib
 Ponatinib

Second line TKI **Start:** / / ---
Month Year **Stop:** / / ---
Month Year
 unknown unknown ongoing
Treatment: Imatinib **Dose** _____ mg/day
 Nilotinib
 Dasatinib
 Bosutinib
 Ponatinib
Reason for regimen change (to second line):
 drug resistance intolerance

Third line TKI **Start:** / / ---
Month Year **Stop:** / / ---
Month Year
 unknown unknown ongoing
Treatment: Imatinib **Dose** _____ mg/day
 Nilotinib
 Dasatinib
 Bosutinib
 Ponatinib
Reason for regimen change (to third line):
 drug resistance intolerance

Additional CML specific therapies

Current treatment Imatinib **Dose** _____ mg/day
 Nilotinib
 Dasatinib
 Bosutinib
 Ponatinib
 Other _____

Most recent molecular result from the local lab

Judgement of molecular result from the local lab No MMR
 MMR
 MR⁴
 MR^{4.5}
 MR⁵
 CMR

Date & Signature

Date / / ---
Day Month Year Sign./Physician Stamp _____

**Adressen der Referenzlabore (für Bluteinsendung)****Benötigt werden 20 ml peripheres Blut (EDTA).****Bitte bevorzugen Sie zum Abschicken die Tage Montag bis Donnerstag!**

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