Uniklinikum Erlangen

Visit initial (DD/MM/YYYY)	_ _ / _ _ / _ _ _ _
	to be filled by study management
CMLpaed II patient ID#:	☐☐☐☐
Date of first diagnosis (DD/MM/YYYY)**:**	_ _ / _ _ / _ _ _ _ **Stage of disease:** ☐ chronic phase ☐ blast phase
Institution/Address:	
Responsible physician:	
Contact	☎_____ @_____
date of birth (DD/MM/YYYY)**:**	_ _ / _ _ / _ _ _ _
sex: ☐ male ☐ female	**Anthropometric data at diagnosis:** **Bodyweight: _____ kg Length:_____cm** Parental height: Mother: Length:_____cm Father: Length:_____cm

Reason for diagnosis:

☐ CML detected incidentally (during preventive care or other medical procedure)
☐ leukemia-related symptoms caused contact with physician

First symptoms:

drop in performance	☐ no	☐ yes	weariness	☐ no	☐ yes
fever	☐ no	☐ yes	bone pain	☐ no	☐ yes
organomegaly-related	☐ no	☐ yes	abdominal pains	☐ no	☐ yes
loss of body weight	☐ no	☐ yes	infections	☐ no	☐ yes
haemorrhagic symptoms	☐ no	☐ yes	others:_____		

Additional complaints / underlying diseases/ regular medication:

_____

_____

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General performance (ECOG-score) – Date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _

☐ 100%: fully active, normal

☐ 90%: minor restrictions in physically strenuous activity

☐ 80%: active, but tires more quickly

☐ 70%: both greater restriction of, and less time, spent in active play

☐ 60%: up and around, but minimal active play keeps busy with quieter activities

☐ 50%: gets dressed, but lies around much of the day, no active play, able to participate in all quiet play and activities

☐ 40%: mostly in bed, participates in quiet activities

☐ 30%: in bed, needs assistance even for quiet play

☐ 20%: often sleeping, play entirely limited to very passive activities

☐ 10%: no play, does not get out of bed

☐ 0%: unresponsive

Examinations at diagnosis:

Clinical examination: (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

▪ splenomegaly: □ no □ yes, _____cm below left costal margin (mid-clavicular line)

▪ hepatomegaly: □ no □ yes, _____cm below right costal margin (mid-clavicular line)

▪ extramedullary manifestation: □ no □ yes, location: □ lymph nodes □ skin

▪ additional clinical pathological findings:

_____

Ultrasound: (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

→ regular □ yes □ no, give details or attach written report: _____

Ocular fundus: (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

→ regular □ yes □ no, give details or attach written report: _____

Tanner Score: (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

Pubic hair development:

☐ PH° 1 ☐ PH° 2 ☐ PH° 3 ☐ PH° 4 ☐ PH° 5

♀ Breast development:

☐ B° 1 ☐ B° 2 ☐ B° 3 ☐ B° 4 ☐ B° 5 Menarche: □ yes, (MM/YYYY) _ _ / _ _ _ _ □ no

♂ Genital development:

☐ G° 1 ☐ G° 2 ☐ G° 3 ☐ G° 4 ☐ G° 5

Patients < 15 years of age at diagnosis:

Left hand bone age radiograph: (DD/MM/YYYY) _ _ / _ _ / _ _ _ _ Bone age: _ _ , _ _ years

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Laboratory analysis at diagnosis
(Provide here or add lab report)

Blood count: date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _

Leukocytes (µl)	
Thrombocytes (µl)	
Erythrocytes (Mio/µl)	
Hb (encircle [g/dl] or [mmol/l])	
MCV (fl)	

Blasts (%)	
Promyelocytes (%)	
Myelocytes+Meta (%)	
Bands (%)	
Neutrophils (%)	

Eosinophils (%)	
Basophils (%)	
Monocytes (%)	
Lymphocytes (%)	
Reticulocytes ([‰] or [%])	
Normoblasts (%)	

Blood chemistry: date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _

	value	unit
Bilirubin (total)		
ALAT		
ASAT		

	value	unit
Gamma-GT		
LDH		
Uric acid		

	value	unit
Creatinine		
Alkaline Phosphatase		

Bone marrow differentiation: date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ (please add photocopy of laboratory result)

Blasts (%)	

Promyelocytes (%)	

Myelocytes+Meta~ (%)	

Bone marrow biopsy: date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ (please add scan of laboratory result)

cellularity: _ _ _ % grad of fibrosis: _ _

Cytogenetic analysis of bone marrow: date (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ (please add scan of laboratory result)

Location of laboratory:_____

method: □ G-banding [□ interphase; □ metaphase] □ FISH

Number of analyzed mitoses_____

□ Ph^+ positive: → _____% Ph^+ cells
□ Ph^+ negative

normal karyotype: □ yes □ no

karyotype:_____

_____

Additional abnormalities: _____ □ none
Chromosomal abberations:_____ □ none

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CML specific treatment:

Tyrosinekinase therapy with □ Imatinib / □ Dasatinib /□ Nilotinib / □ Bosutinib

start of therapy (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ dose:_____ mg

additional therapy: □ none □ yes, give details: _____

_____

Remarks:

_____	_____	_____	_____
Date (DD/MM/YYYY)	Name (Readable)	Signature	Hospital (Stamp)

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