UKALL14 Trial Number 14 Patient Initials

FAX MESSAGE

POST INDUCTION TREATMENT ALLOCATION

DATE (DD/MM/YYYY): ☐☐ ☐☐ ☐☐☐☐

ATTENTION: UKALL14 TRIAL TEAM

FAX No: 0207 679 9861

Number of pages (including cover sheet): ☐☐

CENTRE:	
CONSULTANT:	
RESEARCH CONTACT:	
PHONE NO:	
FAX NO:	

UKALL14 Trial Number 14 Patient Initials

Post Induction Treatment Allocation (1/3)

To be completed for all patients in CR at the end of Phase 2 Induction

Does the patient have a sibling donor? (1=Yes, 2=No, 3=ND) ☐

NO or ND

Is the patient High or Standard risk (1=High, 2=Standard) ☐

HIGH

STANDARD

YES

Is a protocol* donor available? (1=Yes, 2=No, 3=ND) ☐
8/8 MUD donor for **any High Risk factor*
7/8 MMUD **or cord blood for High Risk on cytogenetics **or** MRD only. (Protocol section 5.6.1)*

Continuing with protocol treatment (1=Yes, 2=No) ☐

NO or ND

NO

YES

YES

PLEASE COMPLETE SECTION A

Suitable (eligible/fit/pt choice) for transplant? (1=Yes, 2=No) ☐

YES

NO

PLEASE COMPLETE SECTION B

PLEASE COMPLETE THE REGISTRATION FOR TRANSPLANT FORM

PLEASE COMPLETE THE REGISTRATION FOR MAINTENANCE FORM

UKALL14 | Trial Number: 14 | Patient Initials:

Post Induction Treatment Allocation (2/3)

Section A

To be completed for patients without a suitable protocol donor or standard risk patients who will not be continuing with protocol treatment (including patients for whom a donor search was not carried out for any reason)

Will the patient be continuing with intensification, consolidation & maintenance? (1=Yes, 2=No) [ ]

YES

PLEASE COMPLETE THE REGISTRATION FOR MAINTENANCE FORM

NO

Will the patient proceed with a transplant with a non protocol donor? (1=Yes, 2=No) [ ]

YES

Please specify type of non protocol donor: [ ]

1= Cord blood*
2= Haploidentical
3= Other Mismatched Related
4= Mismatched unrelated*

7/8 MMUD **or cord blood for High Risk on Pt Age **or** WBC only (Protocol section 5.6.1)*

NO

Please specify the planned treatment for this patient:

UKALL14 | Trial Number: 14 | Patient Initials:

Post Induction Treatment Allocation (3/3)

Section B

To be complete for patients with a suitable protocol donor but who do NOT fulfil the suitability criteria for a transplant

Please indicate the reason why the patient is not suitable for transplant:
(1= Patient not fit for transplant, 2= Patient refusal, 3= other reason-specify below) ☐

1 →

Please specify reason the patient is not fit for transplant:
(1= organ dysfunction
2= other reason-please specify below:) ☐

2 →

3 →

Will the patient be continuing with intensification, consolidation & maintenance? (1=Yes, 2=No) ☐

YES →

PLEASE COMPLETE THE REGISTRATION FOR MAINTENANCE FORM

NO →

Please specify the planned treatment for this patient:

Completed by:

Signature:

Date completed: d d m m y y y y