STEM CELL OR BONE MARROW TRANSPLANT

Physician's name: _____ Phone number: _____

Facility name: _____ Phone number: _____

Address: _____

Date(s) of transplant: _____

_____

_____

Type(s) of transplant: _____

_____

_____

Source of stem cells or bone marrow: _____

_____

_____

Any major complications from transplant: _____

_____

Chemotherapy prior to transplant? Yes / No

If yes:

Medication name: _____ Total dosage: _____

How given: _____

Radiation prior to transplant? Yes / No

If yes:

Dates of radiation: _____ Area treated: _____

Dose per session: _____ Total dose: _____