(sending institution: please stamp here):

phone: (__________) __________ - ________ extension please

patient label
name, date of birth, address

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CHEMOTHERAPY FORM AVD-Rev

Trial: **AVD-Rev** | **Case ID:** | **CRF ID:**

before cycle 1:
pre-induction therapy with prednisone 100 mg day -7 to 0 and vincristine 1mg, d -7
yes ☐ no ☐

		Cycle No. _____	Cycle No. _____
day 1		day month year	day month year
day 21		day month year	day month year

	day	administered dose in mg:	
Lenalidomide ___ mg p.o. (starting dose)	1-21	___	___
Adriamycin 25 mg/m² i.v.	1+15	___ , ___	___ , ___
Vinblastin 6 mg/m² i.v.	1+15	___ , ___	___ , ___
DTIC 375 mg/m² i.v.	1+15	___ , ___	___ , ___
Pegfilgastrim		☐ yes ☐ no	☐ yes ☐ no
Anticoagulation		☐ yes ☐ no ☐ LMWHeparin ☐ ASA	☐ yes ☐ no ☐ LMWHeparin ☐ ASA
Platelet transfusion		☐ no ___ quant.	☐ no ___ quant.
RBC transfusion		☐ no ___ quant.	☐ no ___ quant.
febrile neutropenia		☐ no ☐ yes	☐ no ☐ yes
hospital. days due to feb. neutrop.		☐ no ___ days	☐ no ___ days
leucocytes < 1000		☐ no ___ days	☐ no ___ days
days thereof with ≥ 38° C		___ days	___ days
laboratory values before therapy:			
Hb g/dl		___ , ___	___ , ___
mmol/l		___ , ___	___ , ___
WBC x $10^3/\mu l$		___ , ___	___ , ___
platelets x $10^3/\mu l$		___	___

side effects CTC grade 1-4?

	____. cycle		____. cycle	
	☐ no		☐ no	
	no	grade	no	grade
Anemia	☐	___	☐	___
Thrombopenia	☐	___	☐	___
Leucopenia	☐	___	☐	___
Neutropenia	☐	___	☐	___
Nausea/ Vomiting	☐	___	☐	___
Mucositis	☐	___	☐	___
GI-Tract	☐	___	☐	___
Urogenital-Tract	☐	___	☐	___
Respiratory-Tract	☐	___	☐	___
Drug fever	☐	___	☐	___
Allergy	☐	___	☐	___
Heart	☐	___	☐	___
Sinus Bradycardia	☐	___	☐	___
other Cardiac Arrythm.	☐	___	☐	___
Hair	☐	___	☐	___
Infection	☐	___	☐	___
Skin	☐	___	☐	___
Desquamating/ Blistering Rash	☐	___	☐	___
Non-Blistering Rash	☐	___	☐	___
Pain	☐	___	☐	___
Nervous System	☐	___	☐	___
Venous Thrombosis	☐	___	☐	___
others: ________ ________	☐	___	☐	___

protocol deviation?

	no	yes
dose reduction	☐	☐
delay of therapy (>14 days)	☐	☐
termination of therapy (if termination, please use the treatment termination report)	☐	☐

if yes, reason:	no	yes
progression under therapy	☐	☐
toxicity	☐	☐
patient's wish	☐	☐
HL-independent disease; *if yes, which:* ________	☐	☐
others:	☐	☐

remarks:

day month year ________ Investigator signature