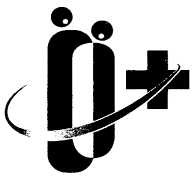


Marrow Donor Program Belgium - Registry
Motstraat 40 2800 Mechelen
Tel: (32) - 15 44 33 96 Fax: (32) - 15 44 36 56
Email : MDPB-registry@rodekruis.be

COURIER & EMERGENCY CONTACT INFORMATION DURING STEM CELL TRANSPORTATION

(To be completed by the center providing the courier)

PATIENT INFORMATION	DONOR INFORMATION
Patient ID:	Donor ID:
Patient Name:	Collection Date(s): (Day/Month/Year)

COURIER INFORMATION

Title :	First name:	Last name:
Mobile Phone Number:		
Date & estimated time of Arrival in Collection Center City: (Day/Month/Year) (h:mm am/pm)		
Passport Number:	Expiration Date: (Day/Month/Year)	Country of Citizenship:

☐ The courier would like the donor center to make hotel reservations for ( ) nights, arriving on . (Day/Month/Year)

☐ The courier will make hotel reservations (details listed below).

Hotel: Address: Confirmation number:	Telephone: Fax:

Transportation by: ☐ air ☐ train ☐ car

PRIMARY ITINERARY TO COLLECTION CENTER (local dates & times to be provided)

Departure Date (Day/Month/Year)	Departure Time (h:mm am/pm)	Airport & City	Airline & Flight #	Arrival Date (Day/Month/Year)	Arrival Time (h:mm am/pm)

BACKUP ITINERARY TO COLLECTION CENTER (local dates & times to be provided)

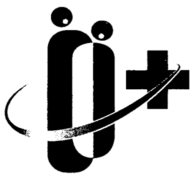
Departure Date (Day/Month/Year)	Departure Time (h:mm am/pm)	Airport & City	Airline & Flight #	Arrival Date (Day/Month/Year)	Arrival Time (h:mm am/pm)

PRIMARY ITINERARY TO TRANSPLANT CENTER (local dates & times to be provided)

Departure Date (Day/Month/Year)	Departure Time (h:mm am/pm)	Airport & City	Airline & Flight #	Arrival Date (Day/Month/Year)	Arrival Time (h:mm am/pm)

BACKUP ITINERARY TO TRANSPLANT CENTER (local dates & times to be provided)

Departure Date (Day/Month/Year)	Departure Time (h:mm am/pm)	Airport & City	Airline & Flight #	Arrival Date (Day/Month/Year)	Arrival Time (h:mm am/pm)



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COURIER & EMERGENCY CONTACT INFORMATION DURING STEM CELL TRANSPORTATION

(To be completed by the center providing the courier)

Comments:	
Name of person completing form:	Title:
Signature:	Date: (Day/Month/Year)

PATIENT INFORMATION	DONOR INFORMATION
Patient ID (assigned by patient's registry):	Donor ID:
Patient Registry:	Donor Registry:
Patient Name:	Collection Date(s): (Day/Month/Year)
Date & Time stem cells scheduled for delivery: (Day/Month/Year) (h:mm am/pm)	Date & Time stem cells expected to be ready for transport: (Day/Month/Year) (h:mm am/pm)

PATIENT REGISTRY INFORMATION		DONOR REGISTRY INFORMATION	
Contact Person:		Contact Person:	
Telephone:	Fax:	Telephone:	Fax:
24 hour Telephone:	Pager:	24 hour Telephone:	Pager:
Email:		Email:	

TRANSPLANT CENTER		COLLECTION CENTER	
Institution:		Institution:	
Delivery Address:		Pick-up Address:	
Contact Person:		Contact Person:	
Telephone:	Fax:	Telephone:	Fax:
24 hour Telephone:	Pager:	24 hour Telephone:	Pager:
Email:		Email:	

Name of person completing form:	Title:
Signature:	Date: (Day/Month/Year)