MAKE-A-WISH®

WISH REFERRAL FORM

A. WISH CHILD INFORMATION

Name: _____ Age/DOB ____/____

Qualifying Medical Condition: _____ Diagnosis Date: _____

End of treatment or Definitive Procedure Date: _____

Sex: ☐ Male ☐ Female Primary Language: _____ County: _____

Permanent Address: _____
Complete Street Address *City* *State* *Zip Code*

Current Address (if different from above): _____

Telephone **( )** _____ Is the child aware of his or her medical condition? ☐ Yes ☐ No
(Area Code)

B. PARENT(S)/LEGAL GUARDIAN(S)

Parent/Legal Guardian: _____	Parent/Legal Guardian: _____
☐ Mother ☐ Father ☐ Other: _____	☐ Mother ☐ Father ☐ Other: _____
Mailing Address: _____	Mailing Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home ( ) _____	Home Telephone: ( ) _____
Work Telephone: ( ) _____	Work Telephone: ( ) _____
Cellular Telephone: ( ) _____	Cellular Telephone: ( ) _____
Email Address: _____	Email Address: _____
Primary Language(s): _____	Primary _____

Siblings/Ages: _____

Does child reside with both biological parents? ☐ Yes ☐ No If no, additional information/paperwork will be required.

C. PHYSICIAN AND MEDICAL INFORMATION

Physician Name: _____ Hospital/Treatment Facility: _____

Office Telephone: **( )** _____ Fax: **( )** _____

Office Address: _____
Complete Street Address *City* *State* *Zip Code*

D. REFERRING PERSON

Name: _____ Relation to child: _____

Telephone: **( )** _____ Fax: **( )** _____

Address: _____ Email _____

How did you hear about Make-A-Wish? _____

Is the family aware of the referral? ☐ Yes ☐ No Referral source e-mail address: _____

E. WISH INFORMATION

Has the child ever received a wish from Make-A-Wish or another organization? ☐ Yes ☐ No

Is the child able to verbalize his or her wish? ☐ Yes ☐ No If no, how does the child communicate? _____

Does the child have developmental delays? ☐ Yes ☐ No _____

Is this a RUSH wish? ☐ Yes ☐ No If yes, please specify _____

COMMENTS: _____

For Office Use Only:

Person taking referral:	**Referral Date:**