



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

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: Code: _____ City, State, Zip: _____

Home Telephone: () _____ Home Telephone: () _____

Work Telephone: () _____ Work Telephone: () _____

Cellular Telephone: () _____ Cellular Telephone: () _____

Email Address: _____ Email Address: _____

Primary Language(s): _____ Primary Language(s): _____

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 Address: _____

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: