



WISH REFERRAL FORM

A. WISH CHILD INFORMATION

Name: _____ Age/DOB: _____ / _____ Sex: Male Female
 Medical Condition: _____ Primary Language(s): _____
 Permanent _____
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 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: () _____
 Address: _____
Complete Street Address City State Zip Code

D. REFERRING PERSON

Name: _____ Relation to child: _____
 Telephone () _____ Fax: () _____
(Area Code) (Area Code)

How did you hear about the Make-A-Wish Foundation®? _____

Is the family aware of the referral? Yes No

E. WISH INFORMATION

Has the child ever received a wish from the Make-A-Wish Foundation 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 time priority: _____

COMMENTS:

For Office Use Only:

Person taking referral: _____	Referral date: _____
Eligibility Confirmed <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ If no, state reason: _____
Wish Team: _____ ; _____	_____ ; _____