



ELLE FOUNDATION INC.
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**CREATING MEMORIES OF JOY FOR CHILDREN WITH CANCER &
GRANTING FINAL WISHES FOR CHILDREN BATTLING A RECURRENCE**

PHYSICIAN'S WISH FORM

TODAY'S DATE: _____

CHILD'S NAME: _____
(Last) (First)

ADDRESS: _____ City _____ State _____ Zip _____

APPLICANT'S AGE: _____ DATE OF BIRTH _____

PHYSICIAN'S INFORMATION:

PHYSICIAN'S NAME PHYSICIAN'S PHONE NUMBER

HOSPITAL and/or PLACE OF TREATMENT

PHYSICIAN'S MAILING ADDRESS

City _____ State _____ Zip Code _____

CONTACT INFORMATION:

SOCIAL WORKER OR CONTACT AT DOCTOR'S OFFICE PHONE NUMBER

CONTACT'S E-MAIL ADDRESS

CHILD'S NAME: _____
(Last) (First)

DIAGNOSIS INFORMATION:

Current Diagnosis

Current Diagnosis Date

Previous Diagnosis

Diagnosis Date / Treatment Dates

Previous Diagnosis

Diagnosis Date / Treatment Dates

Current Treatment – including dates of treatment: _____

IF THE WISH IS FOR TRAVEL IS THE WISH CHILD CLEARED TO TRAVEL:

YES _____ **NO** _____

ARE THERE ANY TIME CONSIDERATIONS FOR THIS WISH (e.g. surgery or treatment dates)?

Does this child require any special apparatus or accommodations (e.g. wheelchair, oxygen)

Does this child require a nurse to travel with them YES _____ NO _____

If yes please provide a separate letter stating that a nurse is medically necessary on your letterhead.

IS THE CURRENT RECURRENCE DIAGNOSIS LIFE-THREATENING: Y N

IS THE CURRENT RECURRENCE DIAGNOSIS LIFE SHORTENING: Y N

CHILD'S NAME: _____
(Last) (First)

COMMENTS OR SPECIAL CIRCUMSTANCES INVOLVING THIS WISH: _____

Do you confirm that this child meets the ELLE FOUNDATION'S criteria for a Second Wish? _____
(See Application Requirements and Guidelines)

PHYSICIAN'S SIGNATURE

DATE

PLEASE ATTACH A BUSINESS CARD FOR THE TREATING PHYSICIAN AND SOCIAL WORKER WITH THIS FORM