

CHILD'S NAME: \_\_\_\_\_  
(Last) (First)



**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:** \_\_\_\_\_

\_\_\_\_\_

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**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)**

\_\_\_\_\_

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**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**