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