

Wish Referral

Child's full name

Male/Female

(Child's date of birth)

Family's daytime telephone number

Mobile number

Mother

Father

Family's full address

Postcode

Please give brief description of child's illness

Name of hospital

Address of hospital

Name of child's Consultant

Consultant's telephone number

Consultant's fax number

Name of referee

Please state your relationship to the child

Your full address (if different from above)

Postcode

Telephone number

Mobile

Fax number

Where did you hear about Make-A-Wish?

Please ensure the medical information release form on the reverse of this page is completed. We need to write to the Consultant in order to establish that the child or young person falls into our criteria. If the young person being referred is over 16 years of age, they must complete this form themselves.

Medical release form

I _____

(parent/guardian) hereby give permission for

(Consultant/Doctor's name)

to release the required medical information regarding

(nominated child's name)

to Make-A-Wish Foundation UK.

Signed: _____ parent/guardian/child*

(delete as appropriate)

*If a child is over 16 years of age they must fill out this form themselves.
The wish application cannot proceed without the above form being signed.

To enable your application to be processed swiftly please return this form to:

**Make-A-Wish Foundation UK,
329-331 London Road, Camberley, Surrey GU15 3HQ**

Should you have any queries whilst completing this form please do not hesitate to contact our Wishgranting Department 01276 405070

www.make-a-wish.org.uk