

Wish Referral

About the child

Child's full name

Male/Female

Child's date of birth

Qualifying illness

Primary language spoken

Has the child received or registered for a wish from another organisation? Yes No Don't know

If Yes, which organisation?

About the family

Parent/guardian name

Home address

Postcode

Home telephone number

Mobile number: Mother

Father

Email address

About the referrer

Name

Your relationship to the child

Your full address (if different from above)

Postcode

Telephone number

Mobile number

Email address

Where did you hear about Make-A-Wish?

About the child's Consultant/Doctor

Name

Name and address of hospital

Telephone number

Fax number

Email address

Medical release form

We need to write to the child's Consultant/Doctor to establish whether they fall within our medical criteria. Please give your permission to release medical information to Make-A-Wish Foundation UK about this child. If the child is over 16, and they are able, they must sign this part themselves.

I, (parent/guardian),

hereby give permission for (Consultant/Doctor),

to release the required medical information regarding (child),

Signed