SPECIAL WISHES, INC.

P. O. Box 391
Oakville, CT 06779
1-860-274-5224

"We Care Beyond the Wish"

PHYSICIAN'S REFERRAL FORM

Child's Name ____ Date of Birth _____________

Address ____

____ Home Phone ____________________

Parents Names ____

Diagnosis ____

Prognosis ____

This child's illness is considered life threatening and he/she should be considered for a wish.

Physician's Signature _______________________________________ Date _____________________

Physician's Name (please print) ____

Physician's Address ____

Physician's Telephone ____

Additional comments (i.e.: is the child able to travel?):

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This form was filled out and submitted to Special Wishes, Inc. by:

Name ________________________________ Phone Number_______________________