aWish with Wings

Granting Magical Wishes since 1982

## REFERRING PARTY:

**Name:** _____ **Relationship to Child:** _____

**Telephone:** _____ **Fax:** _____

**Email Address:** _____

**Is the family aware of the referral?** _____

**How did you hear about a Wish with Wings?** _____

## WISH CHILD INFORMATION:

**Name:** _____ **Gender:** _____

**Age:** _____ **DOB:** _____

**Has the child ever received a wish from us or any other wish granting organization? If yes, please specify:**

_____

**Child's wish request:** _____

## FAMILY INFORMATION:

**Parent/Guardian:** _____ **DOB:** _____

**Home Address:** _____

**Email:** _____ **Phone:** _____ **Cell:** _____

**Parent/Guardian:** _____ **DOB:** _____

**Home Address:** _____

**Email:** _____ **Phone:** _____ **Cell:** _____

**Does the child reside with both parents?** _____

**How many siblings are 18 years of age or younger living at home?** _____

## MEDICAL INFORMATION:

**Primary Diagnosis:** _____

**Treating Physician:** _____

**Physician's Address:** _____

**Physician's Office Number:** _____

**Hospital or treatment facility:** _____

**Is there a medical reason we need to rush the wish?** _____

Please be sure to complete the entire referral form and return to a Wish with Wings by email, fax or mail. Our wish team will be in contact with you to discuss further details.

www.awww.org

**3751 WEST FREEWAY • FORT WORTH, TEXAS 76107 • 817-469-9474 • (FAX) 817-731-3399**