APPLICATION FORM

Mates ON A MISSION

Relationship to Child

Self ☐
Parent/Guardian ☐
Medical Professional ☐
Family Member / Relative / Friend ☐
Other ☐ Please specify _____

How did you hear about us? _____

REFERRER INFORMATION

Title _____ Date of birth _____

Surname _____ Given name(s) _____

Residential address _____

Suburb _____ State / Territory _____ Post code _____

Mobile _____ Daytime telephone _____

Email _____

MOAM CHILD'S INFORMATION

Title _____ Date of birth _____ Gender Male ☐ Female ☐

Surname _____ Given name(s) _____

Has this child ever received a wish grant from any wish granting organisation?

Yes ☐
No ☐
Not Sure ☐

Specify which organisation, and date of wish

_____

_____

In order to facilitate communication, please tick all the boxes that apply to the child you are referring

☐ This child is non-verbal
☐ This child is developmentally on target for chronological age
☐ This child functions at a 0-2 year old, sensorimotor stage
☐ This child functions at a 2-7 year old, preoperational stage
☐ This child functions at a 7-11 year old, concrete operational stage
☐ This child functions at an 11+ year old, formal operational stage
☐ I am not sure

FAMILY INFORMATION

PARENT OR GUARDIAN 1

Relationship to the child _____

Title _____ Date of birth _____

Surname _____ Given name(s) _____

Residential address _____

Suburb _____ State / Territory _____ Post code _____

Mobile _____ Daytime telephone _____

Email _____

What is the families primary spoken language? _____

Please list the child's siblings and their ages

NAME	AGE

Does the parent/guardian consent to this application? Yes ☐ No ☐

PARENT OR GUARDIAN 2

Relationship to the child _____

Title _____ Date of birth _____

Surname _____ Given name(s) _____

Residential address _____

Suburb _____ State / Territory _____ Post code _____

Mobile _____ Daytime telephone _____

Email _____

Does the parent/guardian consent to this application? Yes ☐ No ☐

CHILD'S MEDICAL INFORMATION

What is the nature of the child's medical condition (including diagnosis, prognosis and current treatment needs)

When was the child diagnosed with this condition?

Does the child require any special travel needs?

Treating doctors consulted for the child's medical condition.

DOCTOR'S NAME	ADDRESS	DATE OF LAST CONSULTATION

Tell us in your own words why you think the child your referring should be selected.

SPECIALIST MEDICAL REPORT

This report must be completed by a specialist in the field relating to the terminal medical condition.

MEDICAL PROFESSIONAL'S DETAILS

Title _____ Provider # _____

Surname _____ Given name(s) _____

PATIENT'S PERSONAL DETAILS

Title _____ Date of birth _____

Surname _____ Given name(s) _____

PATIENT'S MEDICAL CONDITION DETAILS

Provide full details of the patient's diagnosis and prognosis

_____

_____

_____

_____

_____

When was the medical condition first diagnosed?

_____

When did the patient last consult you for this condition? When is the next consultation scheduled?

_____

What treatment is planned for the future?

_____

Are there any physical restrictions on the patient's ability to travel travel overseas or participate in any local experience?

Yes ☐ No ☐ If so, please set out all restrictions:

_____

_____

Are there any medical or treatment restrictions on the patient's ability to travel overseas or participate in any local experience?

Yes ☐ No ☐ If so, please set out all restrictions:

_____

_____

What is your estimate of the patient's life expectancy? Less than 12 months ☐ More than 12 months ☐

Please provide any further information that may assist with the patient's application.