DO YOU KNOW A CHILD WITH A LIFE THREATENING ILLNESS WHO WOULD LIKE THE OPPORTUNITY TO GO ON A FAMILY HOLIDAY, SPENDING QUALITY TIME AND MAKING WONDERFUL MEMORIES WITH THOSE THEY LOVE THE MOST.

Mates on a Mission welcomes all applications.

WHO IS ELIGIBLE?

For a child to be eligible for the MOAM Making Memories experience he/she:

1. must be living in Australia;
2. must suffer from a life threatening illness - a progressive, degenerative or malignant condition - supported by evidence from the treating specialist;
3. must ultimately have approval from treating medical specialist to participate in the MOAM holiday/experience.

WHO CAN APPLY OR REFER A CHILD?

Children who may be eligible for the MOAM Making Memories experience can be referred by one of four sources:

1. The child themselves, however consent of legal guardian required if child is below 18 years of age
2. Parents / legal guardians
3. Medical and Allied Health Professionals involved in the treatment and care of the child
4. Family member / Relative / Friend

HOW TO APPLY OR REFER A CHILD?

In order for us to assess the eligibility of the child to participate in the MOAM Making Memories experience, please complete and submit the following forms, along with supporting documents:

APPLICATION FORM

The child and referrer must complete and submit the Application Form to commence the assessment process
To assist us in determining the child's eligibility, please ensure all sections are completed fully and with as much information as possible.

MEDICAL SPECIALIST REPORT

This report must be completed by the child's treating doctor in the field relating to the life threatening medical condition.

PARENTS CONSENT FORM

This form must be completed by the child's parent or guardian.

WHAT HAPPENS AFTER YOU APPLY OR REFER A CHILD?

While Mates on a Mission strive to gift as many experiences as possible, the Board is constrained by resources and cannot unfortunately grant all wishes. With that in mind, the Board will consider all applications against a number of criteria/factors to prioritise applications. These factors include but not limited to prognosis and medical clearance.

If you are successful, you'll be contacted to discuss logistics and make the necessary arrangements.

Any unsuccessful applicant will be notified in writing and can elect to leave their application on file for future consideration.

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.

Signature

Date

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 # _____ Daytime telephone _____

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 ☐

Signature _____ Date _____

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

Signature

Date