**Medical Eligibility Form - Part A**

**This form is used to determine Medical Eligibility**

**INSTRUCTIONS**: This Medical Eligibility Form must be completed and signed by an authorized health care provider who has direct knowledge of the wish child’s medical condition and returned to the address below. Authorized health care provider professionals include licensed allopathic or osteopathic doctors of medicine, certified nurse practitioners and certified physician assistants.

**This form is being signed in connection with a wish that may be granted by Make-A-Wish for:**

Child’s name (“patient”): **<<Lead\_Name>>**

Child’s date of birth: **<<Lead\_DOB>>**

Patient’s qualifying condition:   
ICD-10 code:

Parent(s)/ legal guardian(s): **<<Lead\_Parent\_Last\_Name>> <<Lead\_Parent\_First\_Name>>, <<Lead\_Additional\_Parent\_First\_Name>> <<Lead\_Additional\_Parent\_Last\_Name>>**

Patient’s physician: **<<Lead\_Treating\_Medical\_Professional\_First\_Name>> <<Lead\_Treating\_Medical\_Professional\_Last\_Name>>**

**Please indicate your eligibility determination by checking the appropriate box.**

**PATIENT IS ELIGIBLE –** I am familiar with patient’s physical condition and certify that at *the time of referral* the patient has been diagnosed with a conditionplacing the child’s life in jeopardy. By way of contrast, illnesses that are static or stable do not typically qualify. **NOTE:** *Please use the space below to elaborate on the child’s contributing complications, health conditions and/or level of acuity that is jeopardizing the child’s health such as: number of hospitalizations, reason and length of stay in past 12 months, treatments/treatment failures, or dependence on medical equipment. We may need to contact you for clarification.*

**PATIENT IS NOT ELIGIBLE –**

I am familiar with the patient’s physical condition and certify the patient is not medically eligible at this time.

Authorized Health Care Professional’s Signature Title

Authorized Health Care Professional’s Printed Name Date

Authorized Health Care Professional’s Email Address Authorized Health Care Professional’s Phone Number

This form may only be signed by a licensed allopathic or osteopathic doctor of medicine, a certified nurse practitioner, or a certified physician assistant who has direct knowledge of the wish child’s medical condition.**When completed, please return to:**  
<<Lead\_ChapterName>>

<<LeadOwner\_FullName>>, <<LeadOwner\_Title>>

<<LeadOwner\_Email>>

PH: <<LeadOwner\_Phone>>, FAX: <<User\_Fax>>