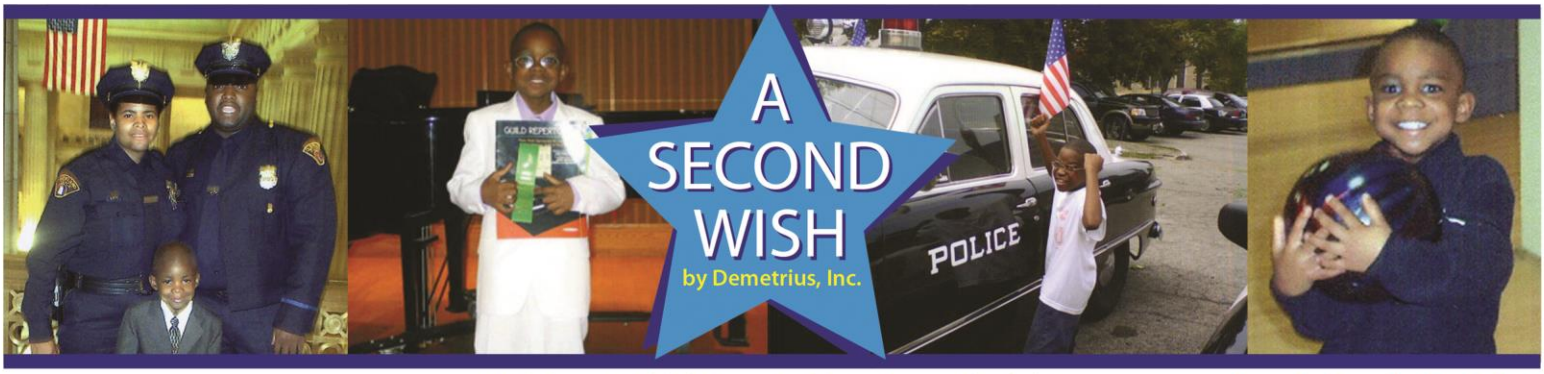

"Giving A Child Hope With A Second Wish" *Angela Small, President*

A Second Wish By Demetrius Inc. Referral Inquiry Form

Wish Child Information

Child's Name: _____ Nickname: _____
Birth Date: _____ Age: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Medical Condition: _____

Parent(s)/Legal Guardian(s) Information

Parent/Legal Guardian: _____ ☐ Mother ☐ Father ☐ Other
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Primary Language: _____

Parent/Legal Guardian: _____ ☐ Mother ☐ Father ☐ Other
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Primary Language: _____

Does child reside with both biological parents? ☐ Yes ☐ No If no, additional information/paperwork will be required.

If there are other children **under the age of 18 in the family, living in home**, please list names and ages:

Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

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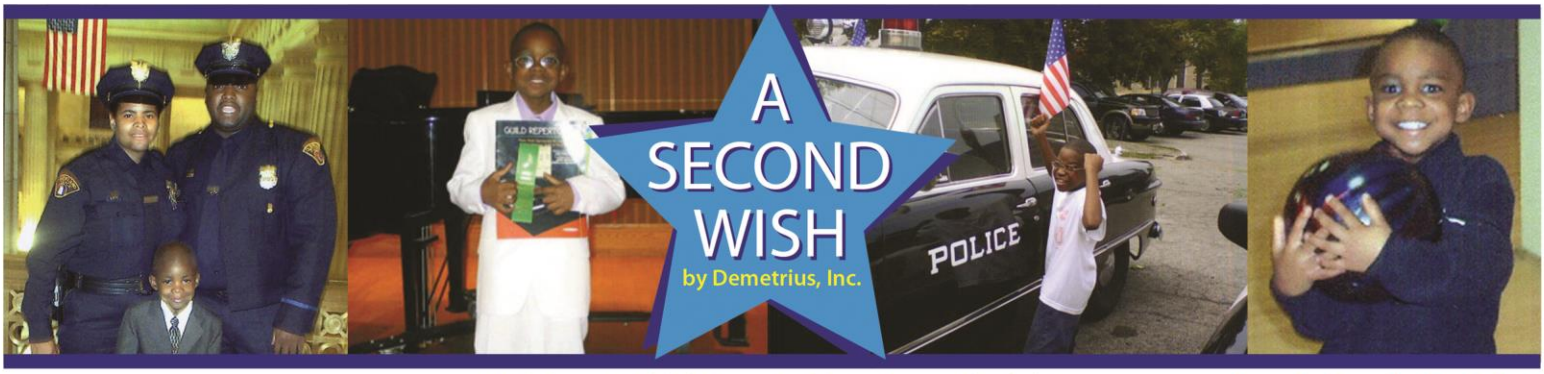

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Physician and Medical Information

Physician's Name: _____

Hospital/Treatment Facility _____

Office Phone:_____Fax:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Referring Person

Name: _____ Relation to child: _____

Telephone: _____Fax: _____

How did you hear about A Second Wish By Demetrius Inc.?: _____

_____

Is the family aware of the referral? ☐ Yes ☐ No

Second Wish Information

Has the child received a wish from another wish granting organization? ☐ Yes ☐ No

If yes, what was the child's first wish ?: _____

Name of Wish Granting Organization_____

Phone:_____ Month: _____Year_____

Is the child able to verbalize his or her wish?: ☐ Yes ☐ No If no, how does the child communicate?

_____

_____

Does the child have developmental delays? ☐ Yes ☐ No

Is this a RUSH wish? ☐ Yes ☐ No If yes, please specify time priority _____

_____

_____

For Office Use Only:

Person taking referral:_____Date: _____

Wish Team Members: _____

Eligibility Confirmed ☐ Yes ☐ No Date:_____If no, state reason: _____

_____

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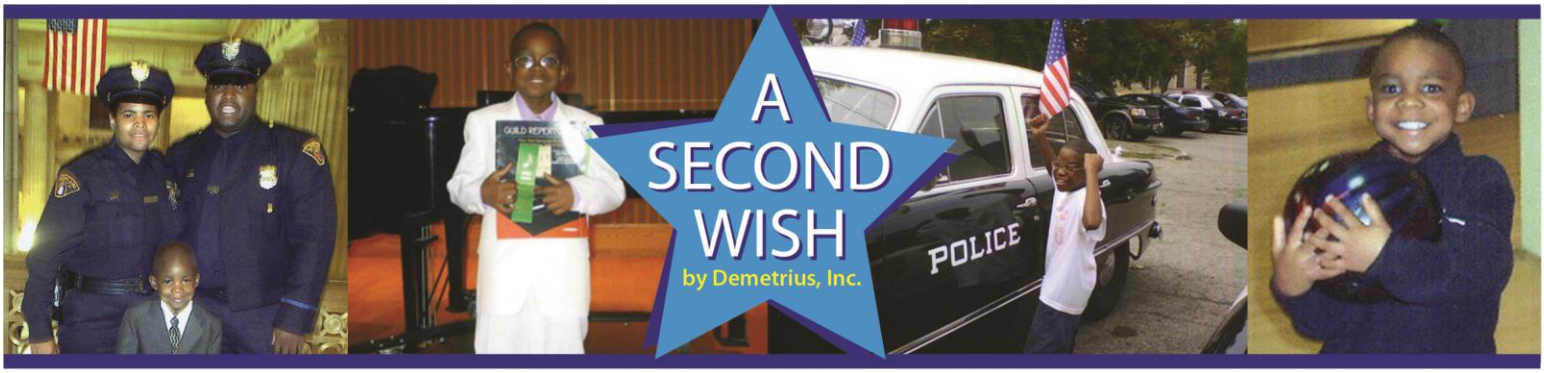

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Required Medical Documentation:

1. Medical Information: The following information MUST be provided by a Qualified Medical Professional:

- A Qualified Medical Professional must be a: Physician, Medical Practitioner or Registered Nurse
- Nominee's Name and Date of Birth
- Nominee's Diagnosis and Prognosis Only (No other medical information is needed)
- Medical Information (MUST BE NO MORE THAN SIX MONTHS OLD)
- **If the Wish Request involves Long Distance Travel: A letter stating the Nominee is medically cleared for long distance travel. (Outside of the nominee's home city)**

2. A photo of the nominee, preferably by email.

How to Submit Documentation:

1. EMAIL: mail@asecondwish.org (Documents must be in a .PDF Format; Photo in a .JPG Format)
2. FAX: 1-800-626-0085
3. MAIL: A Second Wish By Demetrius Inc., - PO Box 25912, Tampa, FL 33622

*The required Medical Eligibility Form must be completed by the Qualified Medical Professional. That form and the nominee's photo and bio must be received **within two weeks** of the application submission in order for your wish request to be considered. If more time is needed, you must contact us to request and extension, otherwise your wish request file will be closed.

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