Portrait Connection

Uniting Children's Health with the Arts

Portrait Connection Portrait Referral Form

Refer a Child & Family

The Portrait Project accepts Referral Forms at any time throughout the year. Please allow 2-3 weeks for your referral to process. If you have any questions please contact: theteam@portraitconnection.org . Please see our website for specific eligibility guidelines: www.portraitconnection.org

Child's Information:

Child(s) Name: _____

Street Address: _____

Gender: _____ Age: _____ Date of Birth: _____

Medical Condition: _____

Family Information:

Parent(s) or Guardian(s) Name(s): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Number of Siblings: _____ Sibling's Names _____

How will a portrait add to this family's experience? _____

Parent's Name Printed: _____

Parent Signature:

_____ Application Date: _____

Photographs: **(Required upon acceptance to the program)**

Please submit 3-5 high-resolution photographs of the child to be used for the portrait with this application. Photographs MUST be clear, good quality photos that show the child in a happy, casual pose. Please include at least 1 close-up of the child's face that depicts eye color and facial details. High-quality photos are required for artists to be able to produce outstanding portraits. If the child attends school and has a recent school photograph, that often provides a clear picture of the child, and should be included among the photos. Photos must be attached to an email and sent after acceptance in the program to: theteam@portraitconnection.org

Additional Information:
Please provide any additional information that you believe would be helpful to the referral process on an attached page.

Please submit page 1 of completed Application Form and Medical Eligibility Form to: **theteam@portraitconnection.org**

For more information please visit: **www.portraitconnection.org**

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Medical Eligibility Form

Parent/Guardian: Please sign below and have your child's physician or medical professional complete and sign the bottom section. The physician or medical professional must be ~~a~~ licensed in your state and have direct knowledge of the child's medical condition.

I authorize my child's medical professional to release the information requested on this form regarding my child's medical condition to Portrait Connection.

_____ _____

Parent/Guardian Signature **Date**

Physician/Medical Professional: Please complete the information below for the patient identified above and indicate your determination by checking the appropriate box.

Physician/Medical Professional Name:

_____

Hospital or Practice Affiliation:

_____

Phone Number: _____ Email: _____

Address: _____

Patient's Diagnosis: _____

- **Patient is eligible based on diagnosis.** I am familiar with the patient's physical condition and will attest that he or she has a life-threatening medical condition that is considered progressive, degenerative, or malignant and that he or she is within 2 years of his or her most recent treatment.

- **Patient is eligible based on hospitalizations.** I am familiar with the patient and will attest that he or she requires frequent or extended hospitalizations and is within 2 years of his or her last inpatient stay.

- **Patient is not eligible.** I am familiar with patient's physical condition, and the patient is not medically eligible at this time.

_____ _____

Physician/Medical Professional Signature **Date**