DREAMS OF JOY
promoting love, protecting hope, providing peace

Medical Information Request:

Dream Applicant's Signature: _____

This Part To Be Completed By Physician Only

Physician's Name:

_____

Physician's Address:

_____

(Including City/State/Zip)

Phone Number: (_____)_____

Fax Number: (_____)_____

If patient is under hospice care
Hospice Name: _____ Phone: (____)_____

Applicant's Diagnosis: _____

Current Life Expectancy in MONTHS: _____

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient has a life expectancy of 18 months or less OR my patient could not actively participate in the requested dream beyond the next 18 months. I certify that my patient is of sound mind, and capable of signing legal documents. I have discussed (or will discuss) the dream request with my patient and have deemed it safe and reasonable if his/her dream is granted within the next three months.

_____ _____ _____

Signature of Physician, NP or PA only Title Date

Please scan and email this form to DreamsofJoyFoundation@gmail.com, OR

*Mail to Dreams of Joy Foundation * 9006 Brixworth Ct. * Old Hickory, TN 37138*