Patient Information

(*To assess eligibility*)

☐ *I confirm that I have obtained appropriate authorization from the patient or their legal representative to share the following information with Unchained Foundation for the purpose of fulfilling their wish.*

Patient First Name: _____ (*Only first name to protect privacy*)
Date of Birth: ____ / ____ / _____
Primary Diagnosis (general description, no specific medical records):
_____

Current Care Setting: ☐ Hospital ☐ Hospice ☐ Home Care ☐ Other: _____

Does the patient have a legal representative or healthcare proxy? ☐ Yes ☐ No
If yes, **Name:** _____
Contact Number: _____

Reason for Referral

(*Please provide a general description while maintaining privacy*)

"This patient was recently diagnosed with a critical illness and is still processing the impact on their life. They have expressed a strong desire to create a special memory with their family while they are still feeling well enough to enjoy the experience. By fulfilling their wish, we have the opportunity to bring hope and compassionate support, building cherished moments for them and their loved ones as they navigate this difficult journey."

_____

_____

_____

Wish Request Information

(*Help us understand how we can make a difference while respecting the patient's privacy*)

Has the patient expressed a wish or dream? ☐ Yes ☐ No
If yes, please describe in general terms (*e.g., "reunite with family," "visit a special place"*):
_____

Does the patient require special accommodations (e.g., wheelchair accessibility, oxygen needs)? ☐ Yes ☐ No ☐
If yes, please explain: _____

Would the patient like family or loved ones involved? ☐ Yes ☐ No
If yes, **how many?** _____

Contact information for family _____

Preferred timing for wish fulfillment (if applicable):
☐ As soon as possible ☐ Within 3 months ☐ Flexible

Patient or Legal Representative Authorization

(*Required for HIPAA compliance*)

☐ *I, the patient/legal representative, authorize the referring healthcare provider to share my general health information with Unchained Foundation solely for the purpose of evaluating and fulfilling my wish. I understand this is voluntary and does not involve sharing medical records or treatment details.*

☐ *I, the patient/legal representative, grant permission for Unchained Foundation to capture and use photographs and/or video footage of my participation in the wish fulfillment process. I understand these materials may be used for promotional, fundraising, or awareness purposes.*

Patient/Legal Representative Signature: _____
Printed Name: _____
Date: ____ / ____ / _____

☐ *I understand that I may revoke this authorization at any time by contacting Unchained Foundation in writing.*

Referring Provider Certification

☐ *I confirm that I have obtained verbal or written consent from the patient/legal representative and that all information provided complies with HIPAA regulations.*

Referring Provider's Signature: _____
Date: ____ / ____ / _____