WISH APPLICATION

APPLICANT'S NAME: _____

MALE: ◯ FEMALE: ◯ AGE: _____ VETERAN? YES ◯ NO ◯

STREET ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

TELEPHONE: _____ EMAIL ADDRESS: _____

DIAGNOSIS: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S TELEPHONE: _____

PLEASE ANSWER THE QUESTIONS BELOW.

IT TAKES 6-8 WEEKS TO PLAN A WISH AFTER ACCEPTANCE

A. HAVE YOU BEEN GRANTED A WISH BY ANY OTHER WISH ORGANIZATION? YES ◯ NO ◯

IF YES, BY WHOM? _____

B. PLEASE LIST "3" WISHES.

1._____

2._____

3._____

C. WHAT DOES HAVING ONE OF THESE WISHES GRANTED MEAN TO YOU (USE A SEPARATE SHEET OF PAPER IF NECESSARY)?

_____

_____

_____

Unity requires a recent picture of you, this can be emailed to: UAJOFH@ATLANTICBB.NET

Please bring page 2 to your physician to fill out completely. All wishes are verified with your physician and the granting of your wish depends on the physician agreeing that you can safely participate in the stated wishes and that your illness is life-limiting. If the physician indicates the illness is not life-limiting, then unity cannot grant the wish.

Both application pages and any additional paper relative to this application must be completely filled out and returned before any planning can begin on a wish.

MAIL TO: UNITY A JOURNEY OF HOPE 239 TOWN COUNTRY RD VANDERBILT, PA 15486

I, hereby allow unity a journey of hope to use my name, likeness, illness, photo and all correspondence in any forum without compensation. I hereby waive my HIPPA rights so unity a journey of hope can speak with my physician about any information included within this application.

APPLICANT'S SIGNATURE: _____ DATE: _____

WISH APPLICATION

APPLICANT'S NAME: _____

I HEREBY WAIVE MY HIPPA RIGHTS AND GIVE PERMISSION TO JOHN ROBINSON R.N. FROM UNITY A JOURNEY OF HOPE TO SPEAK TO MY PHYSICIAN FOR VERIFICATION OF ILLNESS AND HEALTH INFORMATION INCLUDED WITHIN THIS APPLICATION.

APPLICANT'S SIGNATURE: _____ DATE: _____

* * * * * * * * * * * PHYSICIAN'S OFFICE MUST COMPLETE * * * * * * * * * * * *

DIAGNOSIS: _____

OXYGEN USE? YES ◯ NO ◯ IF YES LITERS PER MINUTE

TYPE OF OXYGEN REQUIRED: PORTABLE ☐ LIQUID ☐ CONCENTRATOR ☐

FREQUENCY: AS NEEDED ☐ CONTINUOUS ☐ DEMAND VALVE ☐

CONTACT PRECAUTIONS OR ISOLATION ISSUES? YES ◯ NO ◯

IF YES EXPLAIN: _____

INDEPENDENT AMBULATION? YES ◯ NO ◯

IF NO:

WHEELCHAIR REQUIRED? YES ◯ NO ◯ WALKER USE? YES ◯ NO ◯

NON-WEIGHT BEARING: YES ◯ NO ◯ TRANSFER ASSIST OF: 0 ◯ 1 ◯ 2 ◯

CONTINENCE ISSUES? YES ◯ NO ◯

IF YES WHAT IS REQUIRED?

FOLEY CATHETER? YES ◯ NO ◯ ADULT DIAPERS? YES ◯ NO ◯

INCONTINENT OF BOWEL? YES ◯ NO ◯ INCONTINENT OF BLADDER? YES ◯ NO ◯

ANY SPECIAL MEDICAL REQUIREMENTS UNITY MUST BE AWARE OF? YES ◯ NO ◯

IF YES EXPLAIN: _____

_____

I, VERIFY THAT THIS APPLICANT IS UNDER MY DIRECT CARE. I, FURTHER VERIFY THE DIAGNOSIS STATED IS A LIFE-LIMITING ILLNESS.

I VERIFY THAT HE/SHE CAN SAFELY PARTICIPATE IN THE WISHES STATED IN THIS APPLICATION.

PHYSICIAN NAME (PLEASE PRINT): _____

OFFICE PHONE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____