## Step 3 – Dream Request:

DREAM APPLICANT: _____

Dream Request: _____

Alternative Dream Request (Must be entirely unrelated to first Dream): _____
(If no alternative Dream is listed, only primary Dream request will be pursued)

Participants requested family, spouse, caregiver, and children under the age of 18 living at home:

| PARTICIPANT/CHILD'S NAME: | SEX: | RELATIONSHIP: | AGE: | DOB: |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## Step 4 - Medical Information:

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: (_____)_____
(A Hospice Application that is more expedited is available for social worker to fill out on our website at www.dreamfoundation.org)

**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 12 months or less** OR my patient could not actively participate in the requested Dream beyond the next 12 months. I certify that my patient is of sound mind, and capable to sign 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** |