Referral Form

ELIGIBILITY: Please ensure you have read our eligibility criteria above before submitting a referral. This includes:

- Age/Location: Between the ages of 3-17 and reside within the areas of Southeast Manitoba that SCSS serves
- Diagnosis: Must have an active cancer diagnosis
- You must have prior approval from the child's family before submitting a referral

If you have any questions about the referral process, please contact us at 204-846-HOPE (4673) or info@secancersupport.ca

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Your Full Name: _____ Your Email: _____

Your Phone Number: _____ Relationship to the child you wish to refer: _____

Child's Full Name: _____

Child's Birthdate: _____ _____ (MM/DD/YY) Gender: ____ male ____ female ____ other

Cancer Diagnosis: _____ Date of Diagnosis: _____

Physician's Name: _____ Treatment Hospital/Clinic: _____

Child's Address: _____

City/Town: _____ Postal Code: _____

Family Email: _____ Family Phone: _____

Parent/Legal Guardian 1 – Full Name: _____

Email: _____ Phone: _____

Parent/Legal Guardian 2 – Full Name: _____

Email: _____ Phone: _____

Where did you hear about Wishes of Hope: _____

Do you have a wish option you feel the child would appreciate/has requested: _____

_____

Any additional comments: _____

_____

_____

Program Supporters: Rob Friesen of Re/Max Performance Realty, South East Travel