MEMORIES for kids

Medical Information

This Form To Be Completed By Physician or Physician's Representative

Patient's Name: _____

Physician's Name: _____

Physician's Address: _____
(Including City/State/Zip)

Phone Number: (_____)_____ Fax Number: (_____)_____

If patient is under hospice care:

Hospice Name: _____

Phone: (_____)_____

Patient's Diagnosis: _____

Stage of Cancer: _____

I certify that I am the treating physician or physician's representative of the patient. To the best of my knowledge, my patient has Stage IV cancer, is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the memory request with my patient and have deemed it safe and reasonable if his/her memory is granted within the next three months.

Physician Signature: _____

Date: _____