Medical Form

To be completed by Physician or Hospice Nurse

Patient's Name: _____

Physician's Name: _____

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

Phone: _____

If patient is under hospice care: _____

Hospice Name: _____

Phone: _____

Patient's Diagnosis: _____

Stage of Cancer: _____

I certify that I am the treating physician or hospice nurse of the patient listed above. To the best of my knowledge, my patient has Stage IV cancer, is of sound mind, and capable of signing 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.

Physician Signature: _____

or

Hospice Nurse Signature: _____

Date: _____

Please scan and email to info@memoriesforkids.org or mail to:
Memories for Kids
C/O The Collective
10730 Pacific St, STE 040
Omaha, NE 68114