DESIGN MY ROOM®

PATIENT REFERRAL FORM

Name: _____ Age: _____ Date: _____

For Patient

Sex: **M** or **F**

Length of stay longer than two weeks: **Y** or **N**

Size in pajamas:

_____

Favorite professional sports team:

_____

Person you admire or favorite celebrity:

_____

Hobbies and interests:

_____

_____

Favorite color:

_____

How would you decorate your room and why?:

_____

_____

For Child Life Specialist

Parent/Guardian name:

_____

Parent/Guardian email:

_____

Teen email if over 18:

_____

Contact phone:

_____

Referred by:

_____

Hospital Name:

_____

☐ Patient's name to be kept confidential*

Email completed form to
nancy@wishuponateen.org

Our goal is to make sure that each **DESIGN MY ROOM** is appropriate for each teen. Are there any special considerations that should be kept in mind while choosing items?

_____

_____

**Wish Upon a Teen understands that patient privacy and security is of the utmost importance. The following information will be used only by Wish Upon a Teen for design purposes. If the name privacy is chosen, note that the patient's name will not be mentioned.*