Icing Smiles, Inc. Medical Eligibility Form

Please complete the top section of this form and have your child's physician complete, stamp and sign the bottom section. If you have not yet completed the online application, please do so at... http://www.icingsmiles.org/receive-smile

Child's Name: _____ Date of Birth_____

Parent/Guardian Name: _____

Parent/Guardian Email: _____

Date Completed: _____

PHYSICIAN: Please complete the information below for the patient identified above and indicate your determination by checking the appropriate box. Should you have any questions, contact us at 561-593-8314.

Medical Team Member Name: _____Phone: _____

Hospital Affiliation: _____

Email Address: _____

Hospital/Clinic Address: _____

Patient's Diagnosis (optional): _____

☐ **Patient is eligible.**

I am familiar with the patient's physical condition and will attest that they have a life-threatening medical condition that is considered progressive, degenerative, or malignant, and that they are within 2 years of their most recent treatment.

☐ **Patient is eligible based on hospitalizations.**

I am familiar with the patient and will attest that they require frequent or extended hospitalizations and is within 2 years of their last inpatient stay.

☐ **Patient is NOT eligible.**

Office Stamp or Patient Label is Required:
If no office stamp, please include a Fax Cover sheet with office information.

Physician, Physician's Assistant, Nurse Practitioner, Social Worker, OR Child Life Specialist Signature **Date**

Please return completed form to Icing Smiles Eligibility Team
Via email: icingsmiles@icingsmiles.org - Via fax: 866-724-9389