PROJECT 40 31
STRENGTHENING END OF LIFE STORIES

Medical Authorization Form

This form is to be completed by a Treating Physician, Physician's Assistant, Nurse Practitioner or Registered Nurse ONLY.

As a reminder, the patient application will remain pending until we receive this signed Medical Authorization and supporting documentation.

Patient Name *

First Name | Last Name

Patient's Terminal Diagnosis *

Current Life Expectancy in Months (If less than 1, enter 0). *

Physician's Name *

First Name | Last Name

Physician's Contact Info *

Street Address

Street Address Line 2

City | State | Zip Code

Phone Number

Name of Treatment Facility or Hospital *

Name of Social Worker/Child Life Specialist *

First Name | Last Name

Social Worker/Child Life Specialist Phone Number *

Phone Number

Social Worker/Child Life Specialist Email *

Has the patient been advised about hospice options? *

- Yes
- No

Has the patient declined hospice services? *

- Yes
- No

Please provide details. *

I certify that I am a medical professional treating the patient and acknowledge to the best of my ability that my patient has a **life expectancy of six months or less**. I confirm that all information provided above is accurate. I have discussed Project 4031's service capabilities with my patient and have deemed the request to be reasonable. I recognize that dependent on the request, there are potential risks involved. I have discussed these possible risks and informed my patient that they will assume the full liability of all injuries, damages, or loss, regardless of severity that they may sustain as a result of said participation. To the best of my knowledge I believe my patient is an eligible candidate for assistance and I believe it will improve their quality of life. **I agree to provide documentation on official letterhead stating that this individual is in fact a patient under my care.**

Signature of Medical Professional *

Title of Signer *

Date *