

Dream Request Form

Before filling out this form, please be sure you have reviewed the **Guidelines on Patient Eligibility & Dream Fulfillment** to ensure DreamCatchers can move forward with this Dream experience request.

Patient “Dreamer” Name: _____

Dreamer Age: _____

Former First Responder or Veteran?: **Yes** **No**

If yes, please specify type/branch: _____

Dreamer Representative Name: _____

Relationship to Dreamer (Nurse, Spouse, Relative): _____

Email Address (**required**): _____

Phone Number (**required**): _____

Preferred Contact Method (**required**):

Phone (Call) **Phone** (Text) **Email** **Other** (please specify): _____

Dreamer Consents to Photos/Video (more information on **Liability Release Form attached**): **Yes** **No**

Dreamer Consents to Media/Press: **Yes** **No**

My Dream is to....
