Hair For You Foundation
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Buffalo Grove, IL 60089

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Hair For You Foundation
providing medical hair loss assistance

PHYSICIAN REFERRAL LETTER

Patient's Information

Patient's Full Name ______________________

Date of Birth ____/____/____

Street Address ______________________

Street Address Line 2 ______________________

City ____________ State ______ Zip Code ______

Phone Number (   )   -

Referring Physician's Information *(To be completed by Physician or office personnel)*

Physician's Full Name ______________________

Office Street Address ______________________

Office Street Address Line 2 ______________________

City ____________ State ______ Zip Code ______

Office Phone Number (   )   -

Patient's Primary Diagnosis ______________________

Length of expected treatment ______________________

Is hair loss expected as a result of treatment or condition? ☐ Yes ☐ No

Additional comments: *(optional)*

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Physician's Signature ______________________

Date ____/____/____