Hair For You Foundation
255 N. Buffalo Grove Road, #7366
Buffalo Grove, IL 60089

www.HairForYouFoundation.org

Tel: (224) 543-6533
Fax: (224) 802-3880

info@HairForYouFoundation.org

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)*

_____

_____

_____

Physician's Signature _____ Date ___/___/___

SIGN HERE

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FACSIMILE TRANSMITTAL

To: Hair For You Foundation

Fax: (224) 802-3880

Date:

# of Pages: *(Including cover page)*

From:

Sender's Fax #:

E-Mail:

Re:

Please select included items with fax:

☐ Application ☐ Personal Statement ☐ Referral Letter ☐ Other, specify:

Additional Notes:

Confidential