

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



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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



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FACSIMILE TRANSMITTAL

To: Hair For You Foundation

From:

Fax: (224) 802-3880

Sender's Fax #:

Date:

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of Pages: (Including cover page)

Re:

Please select included items with fax:

Application Personal Statement Referral Letter Other, specify:

Additional Notes:

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