Complimentary Therapy Treatment Referral
Physician's Authorization

Date:________________________

Patient Name:____

Address:____

City: ______________________________________State:_____Zip:___________________

Phone:_________________________E-mail:______________________________________

Physician:____

Physician Phone:____

Client Diagnosis:____

Please select (Circle) ONE service.*
* If more than one service is selected, this authorization is void.

- Skin Care
- Massage Therapy
- Reflexology
- Cranio-Sacral Therapy
- Manicures and Pedicures
- Hand, Foot and Scalp Treatments
- Hair Services

Client must present this referral at time of service along with a Consent/Intake Form, available at www.LHOHH.org or at Garden of Eden Healing Salon & Day Spa.

Comments:____

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Physician's Signature:____

Bringing peace and hope to mind, body & spirit through loving touch.