



Physician's Authorization for Loving Hands of Healing Hope Services

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Physician: _____

Physician Phone: _____

Client Diagnosis: _____

Please select ONE service:

Hair Services

Skin Care

Massage Therapy

Manicures and Pedicures

Hand, Foot and Scalp Treatments

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: _____

Physician's Signature: _____

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

6827 E. Camino Principal ♦ Tucson, AZ 85715 ♦ (520) 954-4508 ♦ Email: info@lhohh.org

www.lhohh.org