



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 (if needed), available at www.lovinghandsofhealinghope.org.

Comments: _____

Physician's Signature: _____