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: _____