APPLICATION FOR HAIR REPLACEMENT

Hair To Help
House L508 Haji Limo Goth
Gulshan-e-iqbal block 3
Karachi
Phone : (021) 36405006
03313098333
Email : hairtohelppakistan@gmail.com

Before sending this application, please ensure that all information is completed and that all of the following documents are enclosed. Otherwise, the application will not be approved.

- **Section 1**: Patient Information
  - Copy of ONE of the following: birth certificate, driver's license, state issued ID or document to show proof of recipient's age
- **Section 2**: Medical Information
- **Section 3**: Referral Information
  - Official signature and office **stamp required**
  - Prescription for a cranial prosthesis (wig)
- **Section 4**: Hair To Help and cranial prosthesis (wig) Receiver agreement

SECTION ONE: PATIENT INFORMATION

how did you hear about Hair To Help?

Patient Name:_____

Age:_____ Date of birth:_____/_____/ _____

Guardian(s) Name(s) (if the patient is under 18) _____

Address:_____

City:_____ State/Province:_____ Zip or Postal Code: _____

Country: _____

Email Address: _____

Telephone: (_____)_____- _____

School/Grade: _____

Are you a past recipient? ❍ Yes ❍ No Date of last application submitted:____/___/____

SECTION TWO: MEDICAL INFORMATION

Reason for hair loss: _____

Please state illness/medical condition: _____

Have you already experienced hair loss? ❍ Yes ❍ No
Are you undergoing medical treatment? ❍ Yes ❍ No
If yes, what type of treatment?_____

Are you currently or will you soon be admitted to the hospital? ❍ Yes ❍ No
If so, for how long? _____

Name of Physician: _____
Hospital/Office address: _____ _____

Do you have a prescription for a cranial prosthesis? ❍ Yes ❍No

SECTION 3: REFERRAL INFORMATION (must be completed in entirety)

Name of Hospital /Organization: _____

Telephone: (_____)_____-_____Email Address: _____

Please circle one: ❍ Doctor ❍ Nurse ❍ Social Worker ❍ other _____

Address:_____

City:_____State/Province:_____Zip: _____

Are you the primary contact for this recipient? ❍ Yes ❍ No

By signing this application, I, as a medical professional, hereby acknowledge and affirm that

1) There is a medical need of this patient for this prosthetic device and
2) This family would otherwise not be able to afford payment of this prosthetic device.

Name of Representative (Please write in capital): _____

Signature of Representative:_____Date:_____/_____/____

An official stamp or documentation from a medical professional (i.e. prescription, doctor's note, etc.) is required. Please attach to application.

Official Stamp Place Here

SECTION 4 : Hair To Help and cranial prosthesis (wig) Receiver agreement

As you know, Hair To Help covers the costs of these customized hairpieces, products, and consultation fees, but as a non-profit organization, we are constantly seeking funds to offset these costs. For each of our recipients, we create a story that focuses on her personality, interests,and personal story with hair loss and with Hair To Help. We value our recipients' privacy, and we do not disclose personal information such as last names, parents' names, addresses, or phone numbers. By signing below, you agree to help us to compile a story by sending us information about yourself, **before and after photos**, and a thank you letter after you receive your hairpiece.

I agree to participate in the "My Story".

X_____ Date: _____

Applicant Signature

X_____ Date: _____

Parent/Guardian Signature (if age below 18)