American Mane
Hair Restoration Clinic
p) 786.373.8811 f) 909.354.3394

Request for Medical Clearance

Physician Name: _____ Physician Phone: _____

Patient First Name: _____ Patient Last Name: _____
Patient DOB: _____
Procedure: _____ Procedure Date: _____

The above stated patient is scheduled for Hair Transplant operation, please indicate if this patient:

____ Is medically cleared for procedure
____ Is NOT medically cleared for procedure
____ Patient need more tests done

***Please perform the following lab tests and send copies of the results:**
-CBC
-BMP
-Hepatitis panel
-HIV PT/PTT
-COVID-19

Please include an updated, detailed HISTORY and PHYSICAL that states that patient is:
"Cleared for hair transplant procedure under LOCAL anesthesia"
Thank you in advance for your prompt response.

Comments:
_____
_____
_____
_____

Signature: _____ Date: _____