

**American Mane
Hair Restoration Clinic
21110 Biscayne Blvd #406
Aventura, FL 33180
p) 786.373.8811 f) 909.354.3394
info@americanmane.com**

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: _____