



AMERICAN MANE
HAIR RESTORATION CENTER

Hair Restoration Clinic
21110 Biscayne Blvd #406.
Aventura FL 33180
info@americanmane.com

Request for Medical Clearance

Physician name: _____

NPI: _____

Patient first name: _____

Patient last name: _____

Patient DOB: _____

Procedure: _____

Procedure Date: _____

The above-stated patient is scheduled for a hair transplant operation, please indicate if this patient:

- Is medically cleared for the procedure
- Is NOT medically cleared for the procedure
- Patient needs 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 the patient is:

"Cleared for hair transplant procedure under LOCAL anesthesia"

Thank you in advance for your prompt response.

Comments:

Physician signature: _____

Clinic phone number: _____

Date: _____