AMERICAN MANE
HAIR RESTORATION CENTER

Hair Restoration Clinic
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Aventura FL 33180
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Fax: (954) 820-7285

Request for Medical Clearance

Ordering 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 (A, B, C)**
-**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:
_____
_____
_____

Attending Physician signature:_____ Clinic phone number:_____
Date: _____