



## I'm Me Again!

### Wig Recommendation Form

#### Program Guidelines

1. To recommend a patient for a free wig, please complete this form and give to your client.
2. To qualify, patient must have hair loss due to medical need, live in the Houston area and have a financial need.
3. Patient will only be able to receive one wig per referral.
4. Form must be stamped with doctor's office letterhead stamp (no copies)

#### Medical Personnel Information

Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name (hospital/office): \_\_\_\_\_ Facility Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone No: \_\_\_\_\_

#### Patient Information

Name: \_\_\_\_\_

Medical Need (yes/no): \_\_\_\_\_

Financial Need (yes/no): \_\_\_\_\_

**PLEASE USE CLINIC STAMP HERE**