



**Physician's Authorization
for Loving Hands of Healing Hope Services**

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Physician: _____

Physician Phone: _____

Client Diagnosis: _____

Please select ONE service:

Hair Services

Skin Care

Massage Therapy

Manicures and Pedicures

Hand, Foot and Scalp Treatments

*Client must present this referral at time of service along with a Consent/Intake Form,
available at www.LHOHH.org or at Garden of Eden Healing Salon & Day Spa.*

Comments: _____

Physician's Signature: _____

Bringing peace and hope to mind, body & spirit through loving touch.

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