



www.ISHRS.org

SHARE YOUR HAIR STORY

The International Society of Hair Restoration Surgery would like to invite you to share your personal hair restoration story. This is your opportunity to share your hair experience with others. Your first name and before/after photos will be used and posted on the ISHRS website (www.ISHRS.org) in the Patient Stories section.

We suggest that you describe your hair restoration procedure and/or an encounter with your physician that stands out as being particularly meaningful or important to you because of its positive effect on your life.

In your story, you may wish to address one or more of the following questions:

- What made this a good experience?
- How did my physician contribute to making this a positive experience?
- How has hair restoration surgery changed my life?
- What would I tell others considering a hair transplant?

Your submission may be edited lightly (mostly for typographical or grammatical errors), but the story will remain in your voice. Please limit your submission to 500-800 words. High quality (untouched) "before and after" photos must accompany submission and be labeled with name, date, and whether "before" or "after". After photos should indicate how many months post-op.

Complete the Patient Story Form indicating that you authorize the International Society of Hair Restoration Surgery (ISHRS) to print and publish your article and photos on the ISHRS website.

SUBMISSION STEPS:

1. **Essay and Photos.** E-mail to: info@ishrs.org (Essay should be in Word format. Photos should be in JPEG format with resolution of 300 dpi.)
2. **Patient Story Form.** Fax signed form to: 630-262-1520 (Or scan and e-mail to: info@ishrs.org)

International Society of Hair Restoration Surgery

303 West State Street, Geneva, IL 60134 USA

Phone: 800-444-2737 or 630-262-5399; Fax: 630-262-1520; E-mail: info@ishrs.org



Patient Story Form

Patient Name: _____

Address: _____

City, State, Country: _____

Telephone: _____ E-mail: _____

Gender: ___ Male ___ Female ___ Transgender

Cause of hair loss (e.g., inherited, injury, medical): _____

Norwood Stage (if applicable): _____

Your Age in the "Before" Photos: _____ Your Age in the most recent "After" Photos: _____

Area Treated (e.g., scalp, chest, eyebrow, beard, etc.): _____

If scalp, further define:

- Hairline
- Crown
- Temples
- Other

Technique(s) used (check all that apply):

Hair transplantation

- Follicular unit transplantation
- Single hair transplantation
- Mini-graft transplantation
- Multi-unit graft transplantation
- Punch graft transplantation

Scalp surgery

- Scalp reduction
- Extensive scalp lifting
- Scalp expanders
- Scalp extenders
- Scalp flaps
- Scalp revision

Special

procedures/considerations

- Browlifting
- Facelift hair revision
- Burned scalp reconstruction
- Follicular unit extraction

Number of procedures: _____

Total number of grafts (if applicable): _____ Total number of hairs transplanted (if applicable): _____

Ethnicity:

- Caucasian/white
- Asian or Pacific Islander
- Black
- Indian
- Middle Eastern
- Latino

- Other

Physician Name: _____

Title of story/essay: _____

PATIENT CONSENT

I consent to the publication, distribution and other use of photographs of me or parts of my body, which have been provided to the International Society of Hair Restoration Surgery ("ISHRS") (the "Photographs"), together with a personal statement regarding my hair restoration surgery and related outcome ("Patient Story"). I represent and warrant that this consent does not violate any copyright, proprietary or personal rights of others, that I have not previously granted any rights to other parties that are inconsistent with this consent, and that I have the authority to grant this consent.

I understand that the Patient Story and Photographs may be published on the ISHRS website for purposes of informing the general public about the benefits of hair restoration surgery. ISHRS reserves the right to edit the Patient Story prior to publication.

I understand that the Photographs may identify or otherwise present a recognizable likeness of me and that my first name may be used on the ISHRS website. I authorize the ISHRS to show my _____ eyes _____ face.* I further understand that the Photographs may be modified in any way that ISHRS or its designees may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given.

I understand that ISHRS undertakes no obligation to publish either the Patient Story or the Photographs.

I grant this consent as a voluntary contribution in the interest of public education and waive any claim for payment in connection with such consent.

I certify that I have read the above Authorization and Release and fully understand its terms.

Patient Signature: _____ **Date:** _____

Patient Name Printed: _____

**Please initial next to those areas which you permit the ISHRS to show. If you do not initial next to "Face," we will crop the photograph so that only your hairline and above shows. If you do not initial next to "Eyes," we will put a black bar over your eyes in the photograph(s).*

PHYSICIAN CONSENT

I consent to the publication, distribution, and other use of the Photographs, along with the publication and/or use of my name in connection with the Patient Story. I represent and warrant that this consent does not violate any copyright, proprietary or personal rights of others, that I have not previously granted any rights to other parties that are inconsistent with this consent, and that I have the authority to grant this consent.

I understand that the Photographs and my name may be published on the ISHRS website for purposes of informing the general public about the benefits of hair restoration surgery. They may be modified in any way that ISHRS or its designees may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given.

I understand that neither the ISHRS's publication, distribution, or use of the Photographs nor the publication and/or use of my name constitutes the ISHRS's endorsement, approval, or recommendation of me or any products, processes, or services I have provided to the patient. I further understand that ISHRS undertakes no obligation to publish the Photographs or my name.

I grant this consent as a voluntary contribution in the interest of public education and waive any claim for payment in connection with such consent.

I certify that I have read the above Authorization and Release and fully understand its terms.

Physician Signature: _____ **Date:** _____

Physician Name Printed: _____

Thank you for sharing your story!