INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

Pro Bono Foundation

OPERATION RESTORE

Restoring self-image, self-esteem and hair

Prospective Patient Application

Mission Statement: The ISHRS recognizes the impact of hair loss due to trauma or disease on a person's well being. The mission of ***Operation Restore*** *is to provide hair restoration surgery to individuals with this type of hair loss and who lack the resources to obtain the corrective surgery on their own. The program will match prospective patients with volunteer physicians in order to serve the community at large.*

1. Patient Name:____

First Middle Last

Address:____

City:________________________ State:________________________

Zip/Postal Code:________________________ Country:________________________

Daytime Telephone:________________________ Evening Telephone:________________________

E-mail:________________________

2. Date of Birth:______________ Age:________ Sex: ❑ Male ❑ Female

3. How far are you willing to travel to receive hair restoration treatment? (Please indicate in miles): ________________

How did you hear about *OPERATION RESTORE?*: ❑ Website ❑ Other:________________

❑ Referred by:________________

4. Please give a brief history of your hair loss/condition (please attach additional pages as necessary):

5. Provide your medical history, including all past surgeries of any type, allergies, and any medications you may be on.

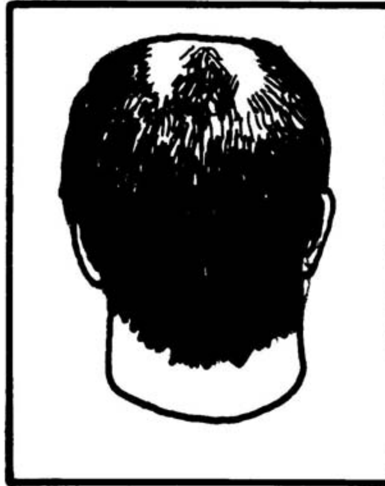
6. Explain your financial needs and qualifications for *OPERATION RESTORE* (please attach additional pages as necessary):

International Society of Hair Restoration Surgery
13 South 2nd Street, Geneva, IL 60134 USA
Phone 800-444-2737 or 630-262-5399; Fax 630-262-1520;
E-mail: info@ishrs.org; Website: www.ISHRS.org

OPERATION RESTORE

Patient Photographic Documentation

Please attach five photographs in the orientations indicated. Feel free to attach additional photographs if you feel they will enhance our understanding of the problem.



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OPERATION RESTORE

Prospective Patient Consent and Release

I, ____, hereby request and consent to participate in the International Society of Hair Restoration Surgery (ISHRS) Pro Bono Program *OPERATION RESTORE*, hereby referred to as the "Program", as a prospective patient.

I fully understand and acknowledge that (i) the ISHRS in no way endorses any medical or surgical techniques addressed and/or used by a volunteer physician; (ii) the Program is not a certified hair restoration program and no way endorses, accredits or certifies the volunteer physicians participating in the Program; and (iii) the Program does not establish a physician-patient relationship between ISHRS and any patient, but rather serves only as a pro bono matching service for prospective patients who wish to participate in the Program and receive pro bono hair restoration treatment.

I further understand and acknowledge that my participation in the Program is entirely voluntary. I may refuse hair restoration treatment by a matched Program volunteer physician and, if I so elect, continue to have ISHRS consider my Application for subsequent match. I may withdraw my application upon written notice to the ISHRS headquarters office. In addition, I understand that the opportunities to be matched with a Program volunteer physician are limited, and that ISHRS undertakes no obligation to guarantee such a match.

In consideration for my participation in the Program, I hereby release the ISHRS and its officers, directors, members and agents from and against any and all liability arising from or in any way connected with my participation in the Program.

I have read the above Prospective Patient Consent and Release Form and agree to be bound by its terms.

Name:____ Date:______________________
(Please Print)

Signature:____

Send completed application to:

International Society of Hair Restoration Surgery
OPERATION RESTORE
13 South 2nd Street, Geneva, IL 60134 USA
Phone 630-262-5399
Fax 630-262-1520
E-mail: info@ishrs.org
www.ISHRS.org

For Office Use Only

Received:________________ By:____

Sent to Committee:____________ By:____

R1__________	R5__________	Surgical Needs:
R2__________	R6__________	❑ AR
R3__________	R7__________	❑ HT
R4__________	R8__________	❑ EX
		❑ FP
		❑ Other:________________

Region:____
____

Ver. 05-05-04