PEDIATRIC

HAIR SOLUTIONS

THE LICE EXPERTS

Patient Referral Form

Date: ____________________

Patient: ____________________

Parent's Name: ______________________________

Referred by Doctor: ____________________________

Name of Practice: ____________________________

Patient Telephone #: __________________________

Lice Treatment Care Referrals:

- ❑ Diagnosis and Treatment
- ❑ Head Lice Treatment

Fax Referral to: 704-496-9512

Email Referral to: info@pediatrichairsolutions.com