Hairs 2 U Wig Bank’s wig donation program will provide you with a comfortable, natural looking wig, hat, or head scarf free of charge. Our goal is to help make this time of healing as easy and stress-free as possible.

Your hospital or social worker must fill out this form for eligibility. This form must be completed prior to your appointment and submitted on the scheduled appointment date. Schedule an appointment by calling the Store Number.

Please Note: If you arrive to your consultation without this form, without exception, we will be unable to proceed.

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Patient Information |  |  | Please Print or Type |  |  |  |  | | --- | --- | | Name: | | | Age: | Sex: |  |  |  | | --- | --- | | Address: |  | | City and State: | Zip Code: |  |  |  | | --- | --- | | Phone Number: | Cell Phone Number: | | Email Address: | |  |  |  |  | | --- | --- | --- | | Signature: | Date: |  | |

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Agency Information |  |  |  |  |  |  | | --- | | Agency Name: | | Agency Address: |  |  |  | | --- | --- | | Social Worker’s Name: |  | | Social Worker’s Number: |  |  |  |  | | --- | --- | | Social Worker’s Signature: | Date: | | Comments: | | |  | | |  | | |

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | For Office Use Only |  |  |  |  |  |  | | --- | | Employee Name: |  |  |  | | --- | --- | | Wig Name: |  |  |  |  | | --- | --- | | Wig Color: |  | | Additional Items: |  | | Value: |  | | Patient’s Signature (Sign During Consultation): | | | Additional Comments: |  | |