Pro Bono Program

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 facilitate hair restoration surgery for individuals with this type of hair loss 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.*

This program is for patients in financial need who have hair loss due to scarring. Scarring may be a result of trauma, surgical scarring, radiation, burns, inflammatory cicatricial alopecias.

Ineligible: male or female pattern hair loss, surgical scarring as a result of a previous hair transplant, traction alopecia, other.

Applications received: January 1-June 30 will be reviewed around July 31; received July 1-December 31 will be reviewed around January 31.

Date:_____

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. **BRIEF HEALTH HISTORY AND HAIR LOSS HISTORY**
Please give a brief history of your hair loss/condition (please attach additional pages as necessary). If your hair loss is a result of trauma, please share a timeline of your trauma and any operations, surgeries, or treatments that you have had to treat the hair loss. If your hair loss is a result of a disease, please indicate when the disease was diagnosed as well as any treatments.

International Society of Hair Restoration Surgery
1932 S. Halsted St., Suite 413, Chicago, IL 60608 USA
Phone 800-444-2737 or 630-262-5399; Fax 630-262-1520;
E-mail: info@ishrs.org; Website: www.ISHRS.org

5. MEDICAL HISTORY

Provide your medical history, including all health conditions, past surgeries of any type, allergies, and any medications you are currently on.

6. PHYSICIAN CONSULTATION

The consultation form at the end of this application must be completed by an ISHRS physician member. It is your responsibility to arrange and pay for (if there is a charge) the consultation. An application is not considered complete and will not be reviewed unless it is accompanied by the completed and signed consultation form. We have included a cover letter to the consulting physician to explain the program.

The completed and signed consultation form is included:

❑ Yes ❑ No

7. FINANCIAL NEED

a. Qualifying applicants must be in households that are at 200% or below of the poverty level. Please see chart below indicated in U.S. Dollars which constitutes this poverty level. After reviewing this information, is your household at 200% or below the poverty level?

❑ Yes ❑ No

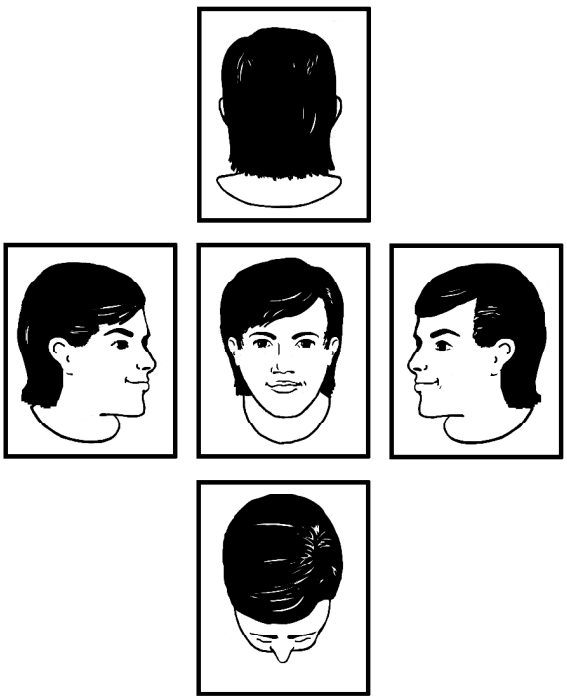
2019 Poverty Guidelines

Number of people in your household	200% of Poverty level
1	$24,980 (U.S. Dollars)
2	$33,820
3	$42,660
4	$51,500
5	$60,340
6	$69,180
7	$78,020
8	$86,860

b. Explain your financial needs and qualifications for *OPERATION RESTORE*. What other economic factors are affecting your ability to have a hair restoration surgery or treatment? You may be asked to supply a pay stub or tax return to substantiate or support the net income of your household.

8. PHOTOS

Please e-mail to us five photographs in the orientations indicated. Be sure your hair is parted to clearly expose the problem area. Feel free to include additional photographs if you feel they will enhance our understanding of the problem. It is necessary for us to see all views of your head to fully assess if you are candidate. Please e-mail the photographs in jpg format/digital camera to Operation Restore at info@ishrs.org.



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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 addition, in the event a match has been made, if mutually acceptable arrangements cannot be agreed upon between the Program volunteer physician and patient, either party can terminate participation.

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:

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Ver. 08-22-19

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LETTER TO THE CONSULTING PHYSICIAN

Dear Consulting Physician,

Prospective patients who apply to the pro bono program of the International Society of Hair Restoration Surgery (ISHRS), called Operation Restore, are required to have a consultation by an ISHRS member as part of the application process. Please complete and sign the attached Operation Restore Consultation Form. The prospective patient should return the Consultation Form with his/her application to the ISHRS.

The Pro Bono Committee of the ISHRS, comprised of physician members, reviews all applications. The Committee determines whether patients qualify for the program and matches accepted patients with volunteer physicians in the program to perform hair restoration surgery.

If you have any questions, please feel free to contact us at:

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Thank you.

Sincerely,

Jerzy Kolasinski, MD, PhD, FISHRS
Chair, Pro Bono Committee
International Society of Hair Restoration Surgery

CONSULTATION FORM

To be completed by the consulting physician

Patient Name:_____
First Middle Last

Date of Birth:_____ Age:_____ Sex: ❑ Male ❑ Female

History of Hair Loss: Please write a short description of the time of onset, duration, location and factors leading to the loss of hair_____

Previous surgeries or medical treatments to correct hair loss:_____

Medical History: previous medical history, pre-existing health conditions, allergies, medications:_____

Patient Name: _____
First Middle Last

Physical Assessment of Hair Loss

Location of Hair Loss: _____

Extent of Hair Loss: _____

Description of the skin that is affected by hair loss. E.g., Is there scarring, irregular, or patchy hair loss? What do any remaining hair follicles in the affected area look like?

_____

_____

_____

What does the rest of the hair on the scalp/other body areas, look like, and what is the potential amount of donor hair available if this patient was to undergo a hair transplant? Please refer to the scalp elasticity, density and caliber of hair in potential donor area. Is there any miniaturization of hair follicles or scarring present? _____

_____

_____

Are other tests required before an accurate diagnosis can be made, e.g., blood tests, biopsy? ❑ Yes ❑ No

Explain: _____

What is your diagnosis as to the cause of hair loss?

- ❑ Male/Female Pattern Hair Loss
- ❑ Telogen Effluvium
- ❑ Alopecia Areata (Discrete or Diffuse) _____
- ❑ Hair loss from Primary Cicatricial Alopecia: *lichen planopilaris, frontal fibrosing alopecia, chronic cutaneous lupus erythematosus, central centrifugal alopecia, pseudopelade (Brocq), alopecia mucinosa, and keratosis follicularis spinulosa decalvans. Cicatricial alopecias that are due to predominantly neutrophilic inflammation include folliculitis decalvans, tufted folliculitis, and dissecting cellulitis, folliculitis keloidalis and erosive pustular dermatosis.* _____
- ❑ Hair loss from Secondary Cicatricial Alopecia: *tumor, radiation, infection, burns*
- ❑ Hair Loss from Trauma
- ❑ Congenital Hair Loss
- ❑ Traction alopecia
- ❑ Trichotillomania
- ❑ Surgical Scarring
- ❑ Surgical Scarring as a result of previous hair transplants
- ❑ Other: Please explain: _____

Are there other factors that should be considered before it is determined if surgery is an option? ❑ Yes ❑ No

Explain: _____

Physician Name: _____

Signature: _____ Date: _____

Physician Address and Contact Details:

May we contact you with questions or if additional information is needed? ❑ Yes ❑ No

Thank you.