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PHYSICIAN'S APPROVAL FORM FOR CLIENTS

Your patient,_________________________________, has expressed interest in receiving massage therapy, myofascial release and or manual lymphatic drainage therapy. during the course of her/his medical care.

I am writing to you to:

1. Outline some common cautions
2. Seek your input on which cautions to use with this client.

My techniques: with most clients I use kneading and stroking techniques and apply compressions (gentle MFR) to the tissues with my hands. I might also do passive stretches and range of motion. I can apply a range of pressures, from just moving the skin (MLD) to deeper work on muscles, as in Swedish massage techniques.

Common factors to consider (check those which apply):

- ☐ **Sites** affected by surgery, cancer, radiation therapy, IVs, drains, skin conditions pain, edema- I will avoid these sites. If there is any nodal involvement with risk of lymphedema, I will use no pressure on the distal extremity and use gentle pressure on the trunk quadrant. I hold a certification in manual lymphatic drainage therapy using the Vodder method.
- ☐ **Easy bruising** /Low platelet counts- I will use gentle strokes that displace only skin and superficial tissues, not deep muscle layers.
- ☐ **Side-effects** of treatments such as chemotherapy and radiation therapy- I will work gently in order to avoid aggravating fatigue, nausea, etc. and will adapt other elements of the session to any presenting side-effects.
- ☐ Any risk of **deep vein thrombosis** secondary to malignancy, -f or cancer treatment- I will avoid pressure on the lower extremities if there is any risk of thrombosis in those areas.

__________________________has my permission to receive relaxation or a treatment specific massage described above. I've read through the common massage therapy adjustments above. I have **checked** any concerns for this patient. If I have any additional concerns for the massage practitioner, I have described them **below**:

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Surgery notes: ____

Medications: ____

Treatment plan: ____

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_________________________________ _____________________

PHYSICIAN'S SIGNATURE DATE

CLINIC NAME, ADDRESS AND PHONE# ____