PHYSICIAN PERMISSION FORM

TO: _____
Name of Physician

Your patient, _____, who has been diagnosed with _____, has requested that I perform a massage on him/her. As an educated oncology massage therapist, I need to comprehend the magnitude of the diagnosis, so that I am capable of administering the proper massage techniques that will benefit our patient, by knowing how to respond to contraindications and any physical conditions.

The massage will be administered using only gentle techniques for the purpose of relaxation, pain management, stress relief and comfort. The session will be specifically adapted to the needs of our patient. When performing the massage, the following issues will be honored:

- Sites affected by surgery, radiation, IVs, skin conditions, pain, edema, tumor site & bone involvement.
- Low platelet levels or low white blood cell count
- Side effects of treatments including chemotherapy, drug therapies and radiation
- Any risk of deep vein thrombosis, secondary to malignancy, inactivity or cancer treatment.

Please read through the common massage therapy adjustments above and circle the relevant issues for this patient. Please provide any additional concerns you have, below.

_____
_____
_____

Strict massage therapy guidelines, including appropriate contraindications and precautions are followed and reinforced throughout the entire massage session.

_____ has permission to receive massage therapy.
Name of Patient

_____ _____
Physician's Signature Date

_____
Print Physician's Name

Thank you for all the information provided; working together we can be sure to give the best care possible!

FROM: _____
Name of Massage Therapy Provider