Physician Approval Form

If you are currently in treatment, between treatments, or if your last treatment for cancer was within one year of the date of the massage session, please download this form, have your physician fill it out, and return it at least 12 hours prior to your appointment.

Dear:

_____

(print name of physician here)

Your patient _____ has expressed interest in receiving massage therapy during the course of her/his cancer treatment.

The session will be specially adapted to the needs of the client. When planning the session design, the massage practitioner will honor, among other medical issues, the following:

• Sites affected by surgery, radiation, IV's, skin conditions, pain, edema, or bone involvement (The therapist will avoid strong pressure on these sites. If there has been any lymph node dissection or radiation of lymph nodes with risk of lymphedema therapist will not use pressure on the distal extremity or trunk quadrant and, if needed, the limb will be elevated during the massage).

• Low platelet levels; easy bruising (The massage therapist will use gentle skin contact instead of pressure).

• Side-effects of treatments including chemotherapy and radiation therapy (The therapist will work gently overall in order to avoid aggravating fatigue, nausea, skin changes etc., and will adapt other elements of the session to any presenting side-effects).

• Any risk of deep vein thrombosis, secondary to malignancy, inactivity, or cancer treatment (The massage therapist will avoid use of pressure on the lower extremities if there is any risk of thrombosis in these areas).

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

_____ has permission to receive relaxation massage described above

(*print name of patient here)*

I've read through the common massage therapy adjustments, above. I've circled the relevant issues for this patient. Any additional concerns I have are described below:

_____

_____

_____

_____	_____	_____
Physician's Signature Date	Print Physician's Name	Today's Date

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