Physician Permission Form

For an upcoming massage therapy session. Please call Leonora Long FS,LMT.
With any questions or concerns, at (239) 878-8648

Dear Physician,

As part of a massage therapy session that has been scheduled.
Your patient _____ has come to me to receive a beneficial and relaxing body massage .As an educated oncology massage therapist I need to comprehend the magnitude of the diagnosis, so that I am capable to administer the proper massage techniques that will only benefit our patient, by knowing how to respond to contraindications and any physical conditions. This letter is a request form provided to all clients currently in cancer treatment or between treatment, and those whose last treatment occurred within the past one year.

The massage therapist who is a qualified will administer only gentle strokes for the purpose of relaxation and comfort. 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 the lymph nodes with risk of lymphedema, therapist will not use pressure on the distal extremity or the 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 ect. And will adapt other elements of the session to any presenting side-effect).***
- Any risk of deep vein thrombosis, secondary to malignancy, inactivity or cancer treatment ***(The massage therapist will avoid use of any pressure on the lower extremities if there is any risk of thrombosis in those areas).***

The massage therapist with 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

Thank you for all the information provided, with working together we can be sure to give the best care possible .

Client Health Form

Thank you for choosing massage therapy as a health care need. The information here is essential to provide you with a safe effective massage therapy session. Please take time to provide as much detail as you can for each question. It is important for your massage therapist to comprehend the magnitude of your diagnosis, so please bring any additional information with you that may assist in the response for any contraindications or physical adjustments that may be needed in your massage to still provide you with a comforting and beneficial session.
You may contact Leonora Long FS.LMT. @ (239) 878-8648 with any questions or concerns.

Your Name_____ Date of Birth_____

Address_____

Telephone# (day) _____ (evening) _____ (cell) _____

Occupation_____

Contact person_____ Relationship_____ PH#_____

E-mail _____@_____

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A).Have you ever had a massage before? Yes / No if yes, were there anything you liked or disliked?

_____

1).When were you first diagnosed with cancer? _____
2).What type of cancer are you diagnosed with? _____
3).Where is your cancer located? _____
4).Is the cancer currently active? _____
5).Are you being treated now? Yes No If no, when was your last treatment?_____
NOTE: ***if you are currently in treatment, between treatments, or if your last treatment session was within one year of the date of the massage session, please have your physician complete the MD permission form.***
6).What ***treatments*** have you undergone, when? ***Please list the dates and types of surgery and other treatments.***_____

_____

_____

7).Current ***medications*** (for cancer or other condition) not described above:
Name of medicine_____ to treat _____
Name of medicine_____ to treat _____
Name of medicine_____ to treat _____
Name of medicine_____ to treat _____
Name of medicine_____ to treat _____
Name of medicine_____ to treat _____

8).Did your treatment include any removal or radiation of lymph nodes? ***If yes please describe where and how many.***_____

_____

9).Did your treatment include radiation therapy? ***If yes please describe where.*** _____

_____

10).Do you have any site restrictions due to:

___ incisions, open wounds, drains or dressings
___ skin sensitivity, rash or skin condition
___ IV, port, ostomy, catheter, or other device***(circle)***
___ a tumor site ___ radiation site ___ neuropathy
___ bone or spine metastasis ___ fracture history
___ area of infection ___history/risk of blood clot
___ other ***(please describe)***_____
_____

11).Do you have any pressure restrictions due to:

___ history or risk of lymphedema ***(circle which)***
___ anticoagulants ___ low platelet count
___ bone or spine metastasis ___ steroid medication
___ fragile / sensitive ___ fragile veins
___ area of pain or burning ___ fatigue
___ recent surgery ___ infection or fever
___ other ***(please describe)***_____
_____

12). Did your doctor restrict any of your activities? Yes No ***If yes so please describe.***_____
_____

13). What kind of activities are you able to participate in? _____
_____

Please give me an idea of your day to day or week to week activities, if any._____
_____
_____

14). Do you have any position restrictions due to:

___incision ___medication ___ostomy ___Tumor site ___difficulty breathing ___tender skin
___swelling or risk of swelling (any body area need elevating?) ***please describe***_____
___medical devices ***please describe***_____
___discomfort ***please describe***_____

15). Has cancer or cancer treatments affected any of the following functions in your body? ***(Circle Current issues and describe)***

___lungs ___liver ___nervous system ___heart ___kidney ___blood counts ___energy level
_____
_____

General Signs and Symptoms	***YES***	***NO***	***COMMENTS***
16).Any ***swelling*** or ***tendency*** to swell anywhere in your body?			
17).Any sites of ***pain*** or ***tenderness*** anywhere In your body?			
18).Any sites of ***numbness*** or ***reduced sensation*** anywhere in your body?			
19).Any areas of ***inflammation***?			

Other Medical Conditions	***YES***	***NO***	***COMMENTS***
20).***Skin conditions***(rashes, infections, itching)			
21).Known ***allergies*** or ***sensitivities***(if you use any physician-approved or well tolerated lotion on your skin, please bring it to be used for you)			
22).***Cardiovascular conditions***(History of heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
23).***Liver*** or ***kidney conditions***(for example: Kidney failure, hepatitis, portal hypertension, ect.)			
24).***Respiratory*** or ***Lung conditions***			
25).Diabetes(describe type, any medication, whether blood sugar is well-controlled, any complications			
26).***Injuries*** (any back, neck, hip or knee problems, Tendonitis, disc injuries, recent fractures)			
27). ***Arthritis*** or ***Joint problems***			
28). ***Digestive problems***			
29). ***Surgery***			