Dear (Physician):

Your patient _____ has asked to receive massage
(name)
therapy during the course of her/his cancer treatment. The purpose of this form is to describe our massage adaptations and request your permission.

The session will be specially adapted to the needs of the client. In massage therapy, these are some of the adaptations we make to a client's cancer treatment:

- Sites affected by surgery, radiation, IV's, skin conditions, pain, edema or bone involvement

  (The massage 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 such as chemotherapy and radiation therapy

  The massage 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 avoids use of pressure on the lower extremities with all clients who are in active cancer treatment, or who are 3−6 months out of treatment).

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

_____ has permission to receive relaxation massage therapy
(Print name of patient)
described above. 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 / Time

_____
Print Physician's Name