EDGEHILL

A Benchmark Lifecare Community

Physician Consent to Therapeutic Massage

Dear Doctor:

Your Patient____has expressed an interest in our Therapeutic Massage Therapy program. This program consists of the following components:

I. Techniques include Swedish Therapeutic Massage, Trigger Point Work, Myofascial Release and Energy Work.

2. May also include some vibrational healing work (use of small bells or other small instruments to induce a deeply relaxing and meditative state).

Please check below:

My patient has a history of:

☐ Low Back Pain ☐ Cardiac Disease ☐ Arthritis

☐ Pulmonary Disease ☐ Cancer ☐ Osteoporosis

☐ Other ________________________________

My patient has the following contraindications to massage therapy:

☐ Severe unstable hypertension ☐ Rheumatoid arthritis ☐ Deep vein thrombosis

☐ Varicosities ☐ Malignancy ☐ Aneurism

☐ Other ________________________________

I have reviewed the above information and agree to the following:

__________ My patient may participate in therapeutic massage.

__________ I DO NOT recommend any massage at this time for my patient.

________________________________M.D. __________________ __________________

Physician Signature Phone Date