

To Physician - Name/Address

Dear Physician - This patient is requesting your approval for comfort oriented oncology massage to improve the quality of life at one of life's most stressful times. Massage has been shown to induce the relaxation response, enhance immune function, improve quality of sleep, improve bowel function, reduce pain, and reduce treatment-related fatigue, nausea, diarrhea and loss of appetite. It further helps to reestablish a positive body self-image and empowers patient participation in the healing process.

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION - This authorization for use or disclosure of medical information is being requested to comply with the terms of the federal HIPAA privacy regulations, 45 C.F.R. § 164.508.

AUTHORIZATION - I hereby authorize communication by and between _____ M.D.

and Ronda Crary, MS, LMT, CMLDT, RYT-200, LMT of my medical records and information.

LIMITATION - This authorization is limited to records and information relevant to my receipt of massage therapy.

DURATION - This authorization shall become effective immediately and shall remain in effect for one year.

NOTICE - Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations.

MY RIGHTS - I may revoke this authorization at any time by written notice to the parties, delivered by certified mail. I have a right to receive a copy of this authorization.

Date: _____ Signature: _____

Pressure Staging of Oncology Massage Techniques

0. No Contact
Subtle energy techniques used without skin contact.
1. Light Lotioning
Pressure typically used to spread/distribute lotion.
Only skin moves. Copious amount of lotion used to avoid drag. Slow speed to monitor pressure.
Maximum pressure for clients who are severely medically frail with highly unstable tissues.
2. Heavy Lotioning
Pressure typically used to rub lotion in.
Skin moves with slight movement of adipose tissue and superficial skeletal muscles.
Maximum pressure for most medically frail clients.
3. Medium Pressure
Slight movement of medium layers of muscle, adipose tissue, and blood vessels. Adjacent joints may move a few degrees. (Used in regular massage to warm up muscles for deeper work.)
Maximum pressure for some clients who have illness but are mobile and manage some ADLs.
4. Strong Pressure – NOT USED IN ONCOLOGY MASSAGE
“Deep tissue” - Good body mechanics and strength required of therapist.
Movement of deep layers of muscle, fascia, tendons, adipose tissue and blood vessels.
5. Deep Pressure – NOT USED IN ONCOLOGY MASSAGE
“Deep tissue”. Movement of deepest layers of muscle, fascia, adipose, blood vessels.

Medical Authorization for Oncology Massage

Patient Name _____ DOB _____ Today's Date _____

Massage Treatment Plan: Slow, rhythmic mix of manual massage techniques. Restrictions on site, pressure and position will be observed as indicated, adjusted for patient comfort. See the reverse side for staging of pressures used from 0 to 3.

Please Note Applicable Medical Precautions

- | | |
|---|--|
| <input type="checkbox"/> IV or central line - distal to site only, 0-3 | <input type="checkbox"/> Breast expander - chest, 0-3; caution in prone pos'n. |
| <input type="checkbox"/> Port - avoid site; caution in prone position | <input type="checkbox"/> DVT - lower limbs, 0-1 |
| <input type="checkbox"/> PEG Tube - abdomen, 0; caution in prone position | <input type="checkbox"/> Thrombocytopenia – general, <100, 0-3 / <50, 0-2 / <20, 0-1 |
| <input type="checkbox"/> Constipation - abdomen, 0-3; clockwise only | <input type="checkbox"/> Anticoagulant therapy – general, 0-2 |
| <input type="checkbox"/> Foley - abdomen, 0; caution in prone position | <input type="checkbox"/> Leukopenia - general, 0-3 / infection precautions, 0-2 |
| <input type="checkbox"/> Ascites - abdomen, 0-1 | |
| <input type="checkbox"/> Col / Iliostomy -abdomen, 0; caution in prone position | |

Immunosuppression - Precautions: _____

Tumor - local, 0-1; Site(s): _____

Incision - local, 0; for _____ weeks after surgery. Thereafter, light work to reorient collagen.

Bone metastasis - local 0-3 to ADL restrictions; Site(s): _____ Activity Restriction(s) _____

Skin rash, burn, wheal, disrupted integrity, hypersensitivity, severe itching, lesion - local, 0

Radiation skin reaction - local, 0-3 depending on skin condition, aloe vera gel only.

Upcoming radiation - Avoid skin products containing metals, alcohol, _____

Nodal enlargement, local, 0-3; # _____; Site(s): _____

Nodal excision, local and distally, 0-3; # _____; Site(s) _____; lymphedema precautions

Nodal irradiation, local and distally, 0-3; # _____; Site(s): _____; lymphedema precautions

Edema - local, 0-2; elevate, treat areas from proximal to distal, within areas from distal to proximal, passive ROM

Lymphedema - local, 0-1; refer for specialized treatment

Hazard to Massage Therapist. Avoid massage for _____ days until _____ (date) following:

cyclophosphamide / thiotepa / etoposide radioactive implant (site) _____

radioactive iodine other _____

Other Restrictions, Instructions or Comments: _____

Signed - Physician or RN _____ Date _____

Please Return To

Telephone

Thank You