Physician's Permission for Advanced Therapeutic & Lymphatic Massage, LLC

My name is April Evanitsky, LMT, CLT-LANA, BCTMB, and I am using this form as a permission slip to allow your patient to receive massage services whether it be a form of lymphatic massage, scar work, myofascial release, Reiki, Rossiter Stretching and or traditional massage to help their over all well being. If you have questions or would like to know more about me, please feel free to call me at 717-364-2092 or visit my web page at www.atlm-llc.massagetherapy.com

(Please Print)

Client's name:_____

Physician's Name:_____

Physician's Address: _____

Physician's Telephone: (_____) _____

I have been treating this patient since_____for the following condition(s):

_____

_____

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note that the following considerations and or medication warrant special concern:

_____

_____

Should you notice anything unusual or suspicious in the treatment or progress of this patient, please notify my office immediately.

Physician's Signature:_____ **Date:**_____