Revision 07/19/2023

Integrative Massage Concepts of Charlotte, Inc.
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Physician/Healthcare Provider's Medical Clearance and Referral for Therapy

Practitioner's Clinic Name: ____

Date: ___ / ___ / _____

Domestic Practice Address: ______________________________

City: _______________ State: _____ Zip: _______

Phone #: ___ ___ ____

Physician/Healthcare Provider's Medical Clearance and Referral for:

Client/Patient Name: ______________________________________

Phone#: _____ ____ ______

Date of Birth: ___/___/_____

Date of Surgery: ___/___/_____

Type of Procedure/Surgery Performed__________________________

Date of Last Exam/Assessment: ___/___/_____

Medical Clearance and Referral given to:

Integrative Massage Concepts and Dorothea Weinschuetz, BCTMB, LMBT #4478, CLT,

Date: ___/___/_____ Type of Therapy Requested: ________________________

Reason for Permission/Referral:

There is no reason to believe that Manual Lymph Drainage (Dr.Vodder-Technique),

Massage and/or Bodywork Therapy will harm a typical client's/patient's healing progress.

However, if applicable, please note the following:

Does the client have any diagnosed medical condition/s? If yes, please list them here legibly:

____

Description of condition/s:

Indications for Manual Lymph Drainage (Dr.Vodder-Technique), Massage and/or Bodywork Therapy (provide specifics):

____

Possible interactions with medications:

Special instructions (we may contact your office for clarification):

____

Medical Clearance and Referral given by:

Physician's full name: ____

Physician's board certification: ___________________________________

Phone: ___ ___ ____

Email: ___________________________

Physician's signature: ___________________________________ Date: ___/___/_____