Medical Release Form

PATIENT INFORMATION | HOSPITAL AFFILIATION

Patient's Name: _____

Patient's Address: _____ City/State/Zip: _____

Patient's Phone Number: _____ Patient's Date of Birth: _____

The above patient is seeking medical clearance to the salon and spa services offered by _____ ,

located at _____ .

The services are offered to help alleviate unwanted side effects of cancer treatments such as insomnia, muscle spasm, dehydration, hair loss, dry, irritated skin, nausea, anxiety and depression. A qualified salon staff will administer the services as deemed appropriate to include:

- massage
- reflexology
- facial
- waxing services
- nail services
- meditation
- yoga
- replenishing scalp treatments
- ammonia free hair dye
- customized haircut/ shave
- cosmetic services
- acupuncture
- Nutritional counselling

Patient must be undergoing treatment for cancer to participate. If you know of any reason why your patient should not participate, please indicate on this form.

By completing the form below, however, you are not assuming any responsibility for our administration of Mondays at Racine salon services.

If you have any questions about the Mondays at Racine program, please call the program headquarters and speak with Program Director, Ms. Rosemary Berger at 631.224.5240.

TO BE COMPLETED BY PHYSICIAN

Please write legibly and choose one.

☐ I recommend the patient NOT participate.

☐ I know of no reason why the patient may not participate.

☐ I believe the applicant can participate, with exception of the following services: _____

Physician's Name: _____

Physician's Hospital Affiliation: _____

Patient must be undergoing treatment for cancer to participate. If you know of any reason why your patient should not participate, please indicate on this form.

Physician's Signature: _____ Date: _____

Address: _____ City/State/Zip: _____

Contact Number: _____