Medical Release Form

PATIENT INFORMATION

Patient's Name: _____ Patient's Phone Number: _____

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

Patient's E-mail: _____ Patient's Date of Birth: _____

The above patient is seeking medical clearance to receive cancer care services at the Mondays at Racine programs.

These 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. Only qualified operators will administer these services as deemed appropriate.

SERVICES INCLUDE:

- Gentle Head Shaving
- Scalp Treatments
- Wig Care & Support
- Haircuts
- Non - toxic Hair Dye
- Non - toxic Make-up Application
- Lashes
- Oncology Facials & Skincare
- Oncology Massage
- Lymphatic Drainage Support
- Bolstering
- Non- toxic Manicures
- Therapeutic Pedicures
- Reiki
- Meditation
- Oncology Yoga
- Nutrition Support / Counseling
- Acupuncture

Patient must be undergoing treatment for cancer to participate.

By completing the form below, you are not assuming any responsibility for our administration of Mondays at Racine 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 631.807.9132 or email info@mondaysatracine.org.

TO BE COMPLETED BY PHYSICIAN

Please write legibly and choose one.

☐ The patient may participate without restrictions.

☐ The patient may participate with the 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: _____

Contact Email: _____