

**WAKE MEDICAL MASSAGE, LLC**  
**Medical Massage • Manual Lymph Drainage (Vodder Technique) •**  
**CranioSacral Therapy & Clinical Bodywork**

600 Gathering Park Circle, Suite 201  
Cary, NC 27519  
Phone: 919.228.9559  
(No Fax Service) | wakemedical.massagetherapy.com

**To the Attending Physician,**

I am a North Carolina Licensed Massage and Bodywork Therapist specializing in Medical Massage, Manual Lymph Drainage (Vodder Technique), CranioSacral Therapy (CST), and other therapeutic bodywork approaches.

Your patient has requested therapy, and I am seeking your medical clearance prior to treatment. The attached **Physician/Healthcare Provider Medical Clearance & Referral Form** is intended to support communication regarding the appropriateness of therapy, relevant medical considerations, treatment precautions, and any recommended modifications.

Potential contraindications or conditions requiring medical review or treatment modification may include, but are not limited to:

- Acute infection, fever, or cellulitis
- Deep vein thrombosis or thrombophlebitis
- Untreated or decompensated heart failure
- Active bleeding or recent hemorrhage
- Compromised kidney or cardiac function
- Blood-thinning medications (anticoagulants)
- Active malignancy without appropriate medical or oncology clearance
- Recent surgery or post-surgical recovery requiring stage-specific clearance

**For CranioSacral Therapy**, please also consider whether the patient's medical history includes any neurological, intracranial, cerebrovascular, or post-traumatic conditions that may require precautions, modification, or medical clearance before CST is provided. The attached form includes a specific section for documenting any CST-related precautions or treatment considerations.

Please indicate on the attached form whether the requested therapy is appropriate and, if so, note any precautions, limitations, areas to avoid, positioning considerations, or other treatment modifications you recommend.

Your guidance is greatly appreciated and will help ensure that treatment is provided within the patient's current medical considerations and in coordination with their healthcare care.

Thank you for your collaboration and for helping support safe, appropriate, and patient-centered care.

**Sincerely,**

**Shashi Lodhia, NC LMBT #11844, CMLDT**

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## PHYSICIAN / HEALTHCARE PROVIDER MEDICAL CLEARANCE & REFERRAL FOR THERAPY

Purpose: This form supports communication between the referring healthcare provider and Wake Medical Massage regarding the appropriateness of therapy, relevant precautions, therapeutic goals, and post-procedure considerations.

### Referring Healthcare Provider

Practice/Clinic Name: \_\_\_\_\_  
Provider Name: \_\_\_\_\_  
Credentials: MD / DO / PA : \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Practice Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Patient / Client Information

Full Name: \_\_\_\_\_  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone: \_\_\_\_\_  
Date Last Evaluated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Surgery/Procedure Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Type/Nature of Surgery or Procedure: \_\_\_\_\_

Medical Clearance/Referral granted to Wake Medical Massage, LLC and Shashi Lodhia, CMLDT, NC LMBT 11844

### Therapy Requested

- ☐ Therapeutic Massage
- ☐ Medical Massage
- ☐ Manual Lymph Drainage (Vodder Technique)
- ☐ CranioSacral Therapy (CST)
- ☐ Myofascial Release
- ☐ Trigger Point Therapy
- ☐ TMJ/TMD Treatment
- ☐ Scar Tissue Mobilization
- ☐ Other

### Medical Clearance Status

- ☐ Cleared without restrictions
- ☐ Cleared with precautions / modifications
- ☐ Not medically cleared at this time

Precaution / modifications: \_\_\_\_\_

### Clinical Diagnosis & Therapeutic Goals

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis / relevant condition: \_\_\_\_\_

Clinical diagnosis and therapeutic goals for referral: \_\_\_\_\_

Relevant medical history, surgery, or current treatment: \_\_\_\_\_

## Provider Clinical Rationale

Please briefly explain why you believe the patient may benefit from the requested therapy. This helps the therapist understand the treatment goal and coordinate care appropriately.

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## Clinical Review — Medical Contraindications & Precautions

Please review and check any items that apply. This checklist is intended to prompt communication and does not replace the referring provider's clinical judgment.

### Conditions requiring resolution, medical direction, or postponement

- ☐ Acute infection (bacterial/viral/fungal)
- ☐ Untreated DVT / thrombophlebitis
- ☐ Decompensated cardiac failure
- ☐ Acute renal failure
- ☐ Unstable hypertension
- ☐ Active malignancy without appropriate clearance
- ☐ Acute inflammation (cellulitis/erysipelas)
- ☐ Fever or systemic inflammation
- ☐ Acute hemorrhage / active bleeding
- ☐ Other

### Relative contraindications / conditions requiring clearance or modified care

- ☐ Controlled cardiac condition / CHF
- ☐ Arrhythmia / pacemaker
- ☐ Chronic kidney disease
- ☐ Chronic liver disease
- ☐ Anticoagulant / blood-thinning therapy
- ☐ Diabetes / neuropathy / fragile skin
- ☐ Bronchial asthma
- ☐ Thyroid disorder
- ☐ Pregnancy (specify week: \_\_\_\_\_)
- ☐ Treated malignancy / oncology precautions
- ☐ Recent surgery (type/date: \_\_\_\_\_)
- ☐ Osteoporosis / fracture history
- ☐ Lymphedema / chronic swelling
- ☐ Other

## CranioSacral Therapy (CST) — Safety Review

For patients receiving CST, please identify any known condition that may require avoidance, modification, medical direction, or postponement.

- ☐ Recent intracranial hemorrhage
- ☐ Known or suspected elevated intracranial pressure
- ☐ Recent skull fracture / significant head trauma
- ☐ CSF leak
- ☐ Unstable / untreated cerebral aneurysm
- ☐ Recent acute stroke
- ☐ Recent neurosurgery
- ☐ Active CNS infection (e.g., meningitis/encephalitis)
- ☐ Chiari malformation requiring precautions
- ☐ Uncontrolled / unstable seizure disorder
- ☐ Other neurological precaution
- ☐ None known / identified

Based on your current knowledge of the patient's medical condition, are there any precautions, contraindications, or treatment modifications you recommend regarding CranioSacral Therapy?

**Treatment Precautions / Modifications**

Pressure / intensity:

Areas to avoid:

Positioning:

Activity / ROM restrictions:

Medication considerations / interactions:

Other special instructions:

**Post-Surgical / Procedure-Related Considerations**

Recommended timing / restrictions:

Therapy may begin after: \_\_\_\_\_ Follow-up / re-evaluation date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Incisions, surgical sites, or areas to avoid:

Other post-procedure restrictions:

Additional post-procedure instructions:

**Additional Medical Information**

Diagnosed medical conditions:

Description of medical condition and/or surgery:

Possible medication interactions:

Special instructions / office may be contacted for clarification:

**Provider Authorization**

Based on the patient's current evaluation and my knowledge of the patient's condition:

- ☐ Patient may safely receive the requested therapy without restrictions
- ☐ Patient may receive the requested therapy with the precautions / modifications documented above
- ☐ Patient should not receive the requested therapy at this time

**Provider**

Physician's Full Name: \_\_\_\_\_

Credentials (Board Certification): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

License / NPI (optional): \_\_\_\_\_

**Additional Provider Comments**

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Return completed form directly to: Wake Medical Massage, LLC • 600 Gathering Park Circle, Suite 201, Cary, NC 27519 • 919-228-9559 • No Fax Service.

Please complete all applicable fields legibly. If significant changes or concerns arise during treatment, please notify the office. Updates at the conclusion of care are appreciated. Forms sent directly to the client/patient via email, electronic, physical, or other means will not be accepted.