Wake Medical Massage, LLC
Medical Massage & Manual Lymph Drainage (Vodder Technique)

Mailing Address: 600 Gathering Park Cir, Ste 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 and Manual Lymph Drainage (Vodder Technique). Your patient has requested therapy, and I am seeking your medical clearance prior to treatment.

Contraindications 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 oncology clearance)
- Post-surgical recovery (requires stage-specific clearance)

Please indicate below whether massage and/or MLD are appropriate, and note any precautions or limitations.

I have attached a Medical Clearance and Referral Form for your completion. Thank you for your collaboration in ensuring patient safety and continuity of care.

Sincerely,
Shashi Lodhia, NC LMBT 11844, CMLDT
Wake Medical Massage, LLC | 919-228-9559 | wakemedical.massagetherapy.com

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

Practitioner's Clinic Name: _____ Date: ___ / ___ / 202__

Practice Address (USA): _____

City: _____ State: ____ Zip: _____

Client/Patient Full Name: _____

Phone#: _____ – _____ – _____ Date of Birth: ___ / ___ / _____

Date of Surgery: ___ / ___ / ____ Type/Nature of Surgery: _____

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

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

Therapy Requested:

☐ Therapeutic Massage and/or Bodywork
☐ Manual Lymph Drainage (Vodder Technique)

Clearance Status:

☐ Cleared — Patient may receive massage and/or MLD without restrictions.
☐ Cleared with precautions — Safe to proceed with the following modifications/limitations:
_____
_____
☐ Not cleared — Patient should not receive massage and/or MLD at this time.

Clinical Review — Contraindications Checklist (Please review and check any that apply)

Absolute Contraindications (Treatment NOT advised unless resolved):

☐ Acute infection (bacterial/viral/fungal)

☐ Untreated DVT / thrombophlebitis

☐ Decompensated cardiac failure

☐ Acute renal failure

☐ Unstable hypertension

☐ Active malignancy (no clearance)

☐ Acute inflammation (cellulitis/erysipelas)

☐ Fever or systemic inflammation

Relative Contraindications (Require clearance or modified care):

☐ Controlled cardiac conditions (CHF, arrhythmia, pacemaker)

☐ Chronic kidney/liver disease

☐ Bronchial asthma

☐ Diabetes (neuropathy, fragile skin)

☐ Thyroid disorder

☐ Pregnancy (specify week: _____)

☐ Treated malignancy (oncology massage only)

☐ Recent surgery (type/date: _____)

Relevant Considerations (if applicable):

☐ Post-surgical recovery — safe after _____ weeks/months post-op

☐ Anticoagulant therapy — proceed with caution

☐ Cardiac condition — monitor as follows: _____

☐ Oncology — avoid tumor site / proceed under medical supervision

☐ Other: _____

Additional Medical Information:

Diagnosed medical conditions (list): _____

Description of medical condition and/or surgery: _____

Indications/Reasons for referral: _____

Possible interactions with medications: _____

Special instructions (office may be contacted for clarification): _____

Physician's Full Name: _____

Board Certification: _____

Phone#: _____ Email: _____

Signature: _____ Date: ___ / ___ / 202__

Note to Physicians: All fields must be filled legibly. Please return this completed form by mail to the above address. Forms sent directly to the client/patient via email, electronic, physical, or other means will not be accepted. Should you observe any significant changes or concerns during treatment, please notify this office immediately. Updates at the conclusion of care are appreciated.