Wake Medical Massage, LLC
Mailing Address: 600 Gathering Park Cir, Ste 201, Cary, NC 27519
Phone: 919.228.9559 (No Fax Service)
Website: Wakemedical.Massagetherapy.com

To The Attending Physician,

I am a North Carolina Licensed Massage & Bodywork therapist with specialized training in Manual Lymphatic Drainage (MLD). Your patient has requested treatment, and I would like to confirm medical clearance before proceeding due to their health history.

Contraindications to massage/MLD may include:

- Acute infection, fever, or cellulitis
- Deep vein thrombosis
- Untreated congestive heart failure
- Active bleeding
- Compromised kidney or cardiac function
- Blood-thinning medications
- Malignancy
- Post-surgical recovery (requires stage-specific clearance)

Could you please indicate whether therapeutic massage and/or MLD are appropriate for this patient, and note any precautions or modifications you recommend?

I have attached a consent form for your review and can be reached at 919.228.9559 with any questions. Thank you for your collaboration in ensuring patient safety.

Sincerely,
Shashi Lodhia, NC LMBT11844, CMLDT

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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.

Relevant Considerations (if applicable):

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

☐ Anticoagulant therapy — proceed with caution

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☐ 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.