Scripps Center for
Integrative Medicine

Maternity Healthcare Provider's Medical Release For Therapeutic Massage During Pregnancy

I, ____ authorize my personal physician Dr________________________________ to complete the following form for the purpose of medical clearance for prenatal therapeutic massage.

These services are provided as adjunctive health care. When an individual's pregnancy is high risk, or she has experienced complication or contraindicated conditions, it is our policy to work with her only if her maternity healthcare provider has reviewed this request. Please verify your clearance of this request by your signature below. Please also list any precautions or limitations which you feel to be appropriate. Thank you for your assistance.

REPORT OF PHYSICIAN

Please indicate the appropriate response:

☐ I know of no reason why this patient may not participate

☐ I believe this patient can participate, but I urge caution because:

____

____

☐ I recommend that this member NOT participate because:

____

____

Physician Signature: __________________________________ Date:_______________________

Address: ____

Telephone Number: ___________________________________ Fax Number: ________________

Please bring this completed form to your first appointment.