**Massage Referral Form**

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| **Resident/Patient Name:** |  | | **M / F** | **Ward** | Choose an item. |
| **Ext** |  | **Date of Birth:** |  | | |
| **Referred by:** |  | | | | |
| **Referral for which type of massage** | Choose an item. | | | | |
| **Date of Referral:** | Click or tap to enter a date. | | | | |

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| **Medical Conditions (Please state Yes or No – if Yes please describe)** | | | | |
| Any acute injury, illness or operation in the last two years? | Allergies: | | Varicose Veins  Phlebitis  Thrombosis DVT |  |
| Diagnosis: |  | | | |
| Other: | Epilepsy: | | Contact Lenses: | Asthma: |
| **Resus Status:** | A.R. | D.N.A.R | **Date of most recent Review:** |  |

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| --- | --- | --- | --- | --- |
| **Attached Guidelines *(Please tick as applicable)*** | | | | |
| **Washing and dressing** | **Moving and Handling** | **Communication** | **Interaction/Behavioural management guidelines** | **Other** |
|  |  |  |  |  |
| **Limitations:** (*Please state any limitations within the activity that may exist for this individual. May include managing expectations or specific requests from the individual and family)* | | | | |
|  | | | | |
| **Facilitation support required:** *(e.g. Independent/requires one to one /adaptive equipment required)* | | | | |
|  | | | | |
| **Recommendations from assessment:** *(to enable accessibility to an activity or to recommend management strategies in an existing activity)* | | | | |
|  | | | | |

**Please Ensure the Consent is Gained & Signed BEFORE sending referral**

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| **Consent to Referral** |
| **By** Choose an item. |
| Signature: …………………………………………………………………………….. Date………………………………………………………………………..  Print Name: ………………………………………………………………………………………………………………………………………………………………… |

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| **Consent to cost and payment for massage** |
| **By** Choose an item. |
| Signature: …………………………………………………………………………….. Date: ……………………………………………………………………..  Print Name: ……………………………………………………………………………………………………………………………………………………………… |

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| **NOK details – provided for massage therapist to make contact** |
| **NOK name: …………………………………………………………………………………………………………………………………………………………..**  **NOK contact number: …………………………………………………………………………………………………………………………………………..** |

**Please Note:**

1. **Before massage can be processed the patient/resident is required to have an RHN account with adequate funds to cover the cost and frequency of the therapy requested.**
2. **Before the massage can be processed a one off mandatory assessment has to take place (no massage included) the cost is £16.00.**

**Any additional information required please contact the Leisure & service department.**

[**LeisureandFamilyServices@rhn.org.uk**](mailto:LeisureandFamilyServices@rhn.org.uk)