Galter LifeCenter
The science of feeling better

Consent for Watsu Aquatic Therapy Program

Date: _____

Dear Health Care Provider:

1. Your patient, _____, wishes to begin to receive Watsu Aquatic Therapy from a licensed Occupational Therapist and/or licensed Massage Therapist at Galter LifeCenter.

2. Does your patient have a current medical diagnosis (please circle)? YES NO

If YES, please specify diagnosis and any precautions and or modifications that are required for your patient to participate in Watsu Aquatic Therapy.

_____
_____
_____

3. If your patient is taking any medications, please indicate the type of medication below and the effect it may have on your patient during passive stretching in a warm water (94-96 degree) aquatic environment.
Type of Medication and Effects:

_____
_____
_____
_____

4. The above-mentioned patient has my approval to receive Watsu Aquatic Therapy at Galter LifeCenter under the supervision and treatment of a licensed Occupational Therapist and/or licensed Massage Therapist with the recommendations and or restrictions above, if any.

Date: _____ Phone: _____

_____ _____
Health Care Provider's Signature Printed Name

*Please fax to 773-878-1173 Attn: Integrative Therapies Manager

If you have any questions regarding the Watsu Aquatic Therapy Program please call 773-878-9936, ext. 7341.