Medical Consent Form

This form is provided to support medical consultation for complementary therapy treatments, where a client has a condition which is a medical contraindication to treatment.

Client Details

Client full name	
Contact number	

Therapy Details

To be completed by, or in consultation with, the complementary therapist.

Treatment proposed	
Medical contraindications	

Medical Advice

To be completed by, or in consultation with, a medical practitioner or consultant.

Further details of medical condition (as appropriate)	
Medical advice pertaining to the proposed treatment	

Signatures

Please sign to confirm the above detail is correct to the best of your knowledge.

GP / Consultant's signature		Date	
Client signature		Date	

Therapist to sign to confirm receipt of the above information. This page should be retained by the therapist along with the client consultation.

Therapist signature		Date	