



Lymphedema Resources, Inc.



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Physician's Approval Form

Patient's name _____ Phone _____ has medical approval to participate in ***Movin' On: Exercise & Movement for Breast Cancer Survivors***, a six week program of one hour sessions per week. I understand that the program includes gentle exercise designed to improve range of motion, energy levels and self image and is conducted by licensed occupational, physical, massage therapists or nurse practitioners who are also Certified Lymphedema Therapists. I also understand that participation is voluntary, allowing the participant to stop and rest at any time he or she desires.

The following restrictions apply (**if none, so state**):

Physician's Name _____

Physician's Signature _____

Office telephone number _____

Date _____

Return the form to Lymphedema Resources, Inc:

- With the patient
- By mail to address above
- By fax to 239/437-1703

Patient's attendance in the program will not be confirmed until physician's approval is received.