

Manual Lymphatic Drainage - Consent and Release Form

About Manual Lymphatic Drainage (MLD)

Manual Lymphatic Drainage is a gentle stretching of the skin to encourage movement of lymph fluid. This specialty service is often recommended before or after surgery, especially if lymph nodes have been impacted, but it can help reduce fluid retention during pregnancy. Anyone can benefit from the slimming effects.

Contraindications

- Uncontrolled heart conditions
- Infection, Fever
- Blood Clots, DVT, Blood Thinners
- Heart Failure
- Active Cancer
- Pain or Unhealed Wounds
- Renal Failure
- Liver Conditions (cirrhosis)
- Cardiac Arrhythmia (AV block)

Additional Considerations for Clients with a **History of Cancer**

Diagnosis (Type/Stage)_____	Are you in remission? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last treatment_____	Have you had Chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had Radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Were Lymph nodes removed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> I have received written permission from your healthcare provider to receive MLD?	<input type="checkbox"/> Please List Other Adjuvant Therapies (ex. Hormones, targeted therapy) _____ _____ _____

Additional Considerations for Clients Who **Have Had Surgery**

Did your surgeon recommend MLD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had MLD before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are experiencing pain swelling or bruising, please indicate where._____ _____	Do you have any Numbness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you noticed any thickening of the tissue (fibrosis)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery or Procedure
Please mark all surgeries/procedures and provide the area(s) and type of procedure(s)					
<input type="checkbox"/> Liposuction_____					
<input type="checkbox"/> Nonsurgical Fat Reduction (ex. CoolSculpt, Kybella, SculpSure, Vanquish) _____					
<input type="checkbox"/> Breast_____					
<input type="checkbox"/> Body Lifts_____					
<input type="checkbox"/> Face & Neck_____					
<input type="checkbox"/> Gender Affirmation Surgery_____					
<input type="checkbox"/> Other_____					

Were drains used following the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have drains in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you wearing compression garments? <input type="checkbox"/> Yes <input type="checkbox"/> No	List any medications related to the surgery _____ _____ _____
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Please Read and Initial Each Item Below

_____ Information about manual lymphatic drainage, potential benefits, effects, risks, and possible alternative therapies have been explained to me and I understand this information.

_____ My therapist has informed me of the contraindications of manual lymphatic drainage, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_____ I have no contraindications for manual lymphatic drainage and am not currently experiencing any symptoms or complications listed above or on the Health History form.

_____ I have been given an opportunity to ask questions about manual lymphatic drainage and have had my questions answered to my satisfaction.

_____ I wish to receive this treatment and agree to communicate to my therapist any physical discomfort experienced during the session.

_____ My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken. I understand I may pause or discontinue the session at any time by signaling my therapist.

_____ I release the massage therapist and New Moon Energy & Massage Therapy LLC from all liability for any harm that may unintentionally result from this treatment.

_____ I further understand that massage is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such.

By signing this form I agree with the statements above and give my consent to proceed with manual lymphatic drainage.

Client Name (Please Print) _____

Client Signature _____ Today's Date _____