**Complementary Therapy Services – GP Consent Form**

**Patient’s Name: …….………………………………………………………………**

NHS Number: …………………………………… D.O.B: ………………………….

Dear Dr.

We can offer a range of complementary therapies to the patients when they come to Havens Hospices. To comply with our protocols and guidelines we would appreciate your co-operation in completing the form below.

Should you have any queries please do not hesitate to contact us.

Yours sincerely,

Complementary Therapy Lead

|  |  |  |
| --- | --- | --- |
| Please indicate if there are any known contraindications to this person receiving the following treatments***. Please circle where applicable***. | | |
| Massage | **Yes** | **No** |
| Aromatherapy Massage | **Yes** | **No** |
| Reflexology | **Yes** | **No** |
| Reiki | **Yes** | **No** |
| If yes, please state | | |

**Doctor’s Name: ………………………………………… Date: ……………………**

**Doctor’s signature: ………………………………………………………………….**

**Please return to: Little Havens Hospices, Daws Heath Road, Thundersley, Essex, SS7 2LH or email to** [havenshospices.lhipu@nhs.net](mailto:havenshospices.lhipu@nhs.net)