(781) 385-9601

www.lookfeelfab.org

"WELLNESS PROGRAM" RELEASE – Filled out by medical personnel

Your client _____, has requested participation in
(CLIENT'S NAME)
_____ program from Looking & Feeling FAB, Inc. (LFF). We provide comfort and relief for
(NAME OF PROGRAM)

Those with cancer, through integrative therapies, alleviating side effects and improving quality of life. All our Estheticians and Massage Therapist are Oncology Trained. LFF is the very first nonprofit of its kind in the country and particularly the only nonprofit to concentrate exclusively on treating cancer skin side effects. We have treated more skin issues for oncology patients than any other organization in existence. LFF has witnessed hundreds of different skin reactions from chemotherapy, radiation, surgery, targeted therapies and immunotherapies and helped hundreds who would otherwise suffer in silence. Every skin side effect differs from person to person and requires a well thought out course of treatment customized to the individual, their situation and where they are in their treatment. Education also become very important to avoid recommending products containing ingredients that may cause irritation or more importantly be responsible for causing cancer. If you would like any additional information, would like to meet with us or are interested in our complimentary "Skin is in" training for Drs and medical staff, please contact us at holly@lookfeelfab.org or 781-385-9601. Treatments are offered in Whitman, Woburn, Norwell and Somerset.

I, _____, represent that _____
(***MEDICAL PROVIDER)*** ***(PATIENT'S NAME)***

has the following condition, _____.
(***TYPE OF CANCER)***

I authorize and release, _____, to receive skin
(PATIENT'S NAME)
care and/or massage treatments, and education as part of services offered by Looking & Feeling FAB, Inc.

Please list any allergies: _____
List any precautions needed to be taken: _____
Additional Comments: _____

Print Medical Professional Name: _____
Medical Professional License Number: _____
Medical Professional Signature: _____
Medical Professional Phone: _____
Medical Professional Email: _____