LivingWell
CANCER RESOURCE CENTER
part of
Northwestern Medicine®

LivingWell Cancer Resource Center Wellness Programs and Services
Medical Release Form

We are requesting approval for your patient (first and last name) _____
DOB____/_____/_____to participate in our Wellness programs.

The goal of our programs are to support healing, reduce stress and fatigue, and improve sleep.

Classes are designed specifically for cancer patients to improve strength, flexibility, range of motion, circulation and balance; and combat common treatment side-effects such as osteopenia/osteoporosis, lymphedema, neuropathy, and pelvic muscle weakness.

Please check the appropriate boxes below:
(Note: All classes are modified for individuals pre or post cancer treatment)

Yoga/Exercise	☐ May participate	☐ Not appropriate at this time
Facials	☐ May participate	☐ Not appropriate at this time
Massage/reflexology	☐ May participate	☐ Not appropriate at this time

_____ ____/_____/_____
Physician or Health Care Provider Signature Date

_____
(Print provider name)

_____ ____/_____/_____
Participant Signature Date

_____
(Print participant name)

Please your completed form to:

Fax: LivingWell Cancer Resource Center, 630-262-1110

or Mail: LivingWell Cancer Resource Center, 442 Williamsburg Ave, Geneva, IL 60134

Questions? Please contact info@livingwellcrc.org , call 630-933-7860 or visit www.livingwellcrc.org