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

Classes are designed specifically to help patients with cancer improve strength, flexibility, range of motion, circulation and balance as well as 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 send your completed form to:

- Email: LivingWell Cancer Resource Center, info@livingwellcrc.org
- Fax: LivingWell Cancer Resource Center, 630.262.1110
- Mail: LivingWell Cancer Resource Center, 442 Williamsburg Avenue, Geneva, IL 60134

For any questions, please call 630.933.7860 or visit www.livingwellcrc.org.