Physician Consent for Services

I certify that ________________________________ is under going active treatment for cancer. I give my consent to The Healing Nest to provide the following services to my patient.

Reflexology	Manicure-we do not cut or trim cuticles
Facials	Pedicure-we do not cut or trim cuticles
Reiki	Massage
Hair & Wig Consultation	Make up

Please circle those that you approve for your patient.

_______________________________ ___________________________ __________

Physician Name (Printed) Physician Signature Date

Patient Name:

Address:

Phone number:

Email:

Emergency contact name & number:

Volunteer's initials:______ (for The Healing Nest office only)