Medical Authorization Form

Your patient has registered at the West Island Cancer Wellness Centre (WICWC) and would like to enroll in the many programs and services offered at the Centre. To participate, we require a signed authorization form from his/her physician.

Name of Patient	Diagnosis	Date of Diagnosis		
		Year	Month	Day

Currently or soon to be undergoing	Does the patient have metastases?
☐ Surgery ☐ Chemotherapy	☐ Yes ☐ No ☐ To be determined
☐ Radiation Therapy ☐ Hormone Therapy	If yes, where?
☐ Other ☐ Immunotherapy	

I, Dr. ____,
(please print)

☐ **<u>DO NOT</u>** authorize the above-named patient to enroll in any of the programs/services offered at the Centre

☐ **<u>AGREE</u>** that the above-named patient may enroll in:

- ☐ **<u>ALL</u>** programs/services offered at the Centre (<u>no restrictions</u>)
- ☐ **<u>SOME</u>** (please specify programs/services authorized between 1 to 5 hereunder)
  - ☐ 1. Exercise
  - ☐ 2. Reflexology
  - ☐ 3. Acupressure
  - ☐ 4. Yoga / TaiChi / QiGong
  - ☐ 5. Massage

Restrictions or relevant information to know

Signature of Physician			Name of Pivot Nurse (please print)	
Date of Signature			Physician's Telephone No.	Physician's Fax No.
Year	Month	Day		

*This form is **mandatory for participation** in our programs and services.*
N.B. Based on the above authorization of your doctor, we recommend participation in only those programs so authorized.
The West Island Cancer Wellness Centre exists to empower people who are experiencing cancer by providing them with compassionate support and comprehensive information for the mind, the body and the spirit.

West Island Cancer Wellness Centre
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