



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 <input type="checkbox"/> Surgery <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Other	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Immunotherapy	Does the patient have metastases? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be determined If yes, where?
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I, Dr. _____, (please print)

<input type="checkbox"/> DO NOT authorize the above-named patient to enroll in any of the programs/services offered at the Centre	
<input type="checkbox"/> AGREE that the above-named patient may enroll in:	
<input type="checkbox"/> ALL programs/services offered at the Centre (<u>no restrictions</u>)	
<input type="checkbox"/> SOME (please specify programs/services authorized between 1 to 5 hereunder)	
<input type="checkbox"/> 1. Exercise	<input type="checkbox"/> 4. Yoga / TaiChi / QiGong
<input type="checkbox"/> 2. Reflexology	<input type="checkbox"/> 5. Massage
<input type="checkbox"/> 3. Acupressure	

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			

*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.*