

Postoperative Recovery Treatment Authorization

We happen to share a client that recently underwent a plastic surgery procedure at your facility and has since experienced postoperative complications that have rendered our services inapplicable without medical clearance.

This form is designed to facilitate communication between the client's PostOp therapist and the surgeon or medical staff for clearance before returning to PostOp-Indur treatments. The client's wellbeing is our utmost priority, and we want to ensure they receive the appropriate care. Please follow these instructions to complete the form.

Please review the client's medical history, surgical procedure details, and current health status to determine their eligibility for returning to postoperative recovery edema decongesting treatments.

Complete the following section based on your assessment:

Authorization for Postoperative Recovery Massage Treatments

I hereby authorize _____ to return receiving postoperative recovery treatments. Treatments may resume on ____ \ ____ \ ____.

Denial of Postoperative Recovery Massage Treatments

I regret to inform you that, based on my assessment, I cannot authorize postoperative recovery treatments for _____ at this time due to persisting medical contraindications.

Date of Authorization/Denial: _____

Medical Provider's Contact Information

Name: _____

Title: _____

Medical Facility: _____

Phone Number: _____

Email: _____

"If you have any questions or require further information, please do not hesitate to contact us at the provided contact details."

We value your expertise and look forward to your prompt response. Thank you for your attention to this matter and for your dedication to the well-being of our valued client.