



Communication and Consent Forms

an online resource
created to accompany

Pre- and Perinatal Massage Therapy:

A Comprehensive Guide to Prenatal, Labor and Postpartum Practice
(Third Edition)

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this resource links to:

Chapter 8, page 272





Communication and Consent Forms

Each page of this document offers a different template to get you started in developing materials that enhance communications between you, your clients and their healthcare providers. They range from quite simple, brief forms to the most detailed. Choose the ones that fit your work situation, governmental parameters, and individual needs. Modify them as appropriate with language that suits you, including personalizing them with a business name, logo, and contact information.

We recommend that you consider having a consent/consult form for your clients to complete, usually along with any intake/health history documents (see Chapter 8, pages 273-274, for the questions that you may want to include in your intake assessment). In addition, you should have available another form for physicians, midwives or other providers to complete when needed; some therapists require verification of healthcare providers' clearance from every client. You may decide that you need several different forms so that you are prepared for a variety of communication needs.

Below are the forms included in this document to communicate with your clients:

- Client's Consent For Massage Therapy
- Prenatal, Labor, and Postpartum Massage Therapy Acknowledgement
- Pregnancy/Postpartum Massage Therapy Information and Consent



Forms to communicate with healthcare providers:

- Health Care Provider's Clearance for Massage Therapy During Pregnancy/Postpartum
- Physician's Clearance for Therapeutic Massage/Bodywork During Pregnancy and/or Postpartum

Feel free adapt the forms below to suit the particular needs of your practice. Note that we have left extra wide headers and footers so that you can insert your own contact information, and modify as necessary.

CLIENT'S CONSENT FOR MASSAGE THERAPY

To: _____ (massage therapist)

I would like to receive massage therapy sessions as a form of adjunctive healthcare. My pregnancy/postpartum recovery has been progressing normally. My prenatal health care provider is:

Name: _____

Phone: _____ (Email) _____

I give my consent for you to confidentially consult with the above provider about our work and my condition as needed to coordinate quality care for me and my baby/babies.

(Client's Signature) _____ (Date) _____



PRENATAL, LABOR AND POSTPARTUM MASSAGE THERAPY ACKNOWLEDGEMENT

This is to acknowledge to my massage therapist, _____ (therapist’s name), the following regarding massage therapy that I receive:

- I have been given and understand information explaining the possible benefits of prenatal and perinatal massage therapy.
- My pregnancy/postpartum is considered low-risk, medically uncomplicated by my healthcare provider.
- I have disclosed all known medical complications, conditions or high-risk factors that I am experiencing.
- I understand the adjunctive healthcare intentions of prenatal and perinatal massage therapy, and I am under the care of a physician or other medical caregiver for any medical concerns I have.

Caregiver’s name: _____

Caregiver’s contact information: _____

I give my consent for you to confidentially consult with my provider about our work and my condition as needed to coordinate quality care for me and my baby/babies.

While massage therapy is generally safe for most pregnant, laboring, and postpartum people, I understand and agree to having massage therapy sessions at my own risk. Should I or my child become either directly or indirectly negatively impacted due to any part of or from a session, I will hold harmless and indemnify the therapist and all associated with the therapist from all claims and liability.

Client signature: _____

Print client name: _____

Date: _____



PREGNANCY/POSTPARTUM MASSAGE THERAPY INFORMATION AND CONSENT

Client Name _____ Date _____

Due Date/Birth date of baby/babies _____

Phone # _____

Email _____

It is our intention to provide you a safe and nurturing experience during or after your pregnancy. There are some conditions we need to be aware of to modify our treatment in the best interest of you and your baby. It is our policy to work with a pregnant or postpartum person only if their medical care provider has reviewed and approved this treatment prior to a first appointment. We are happy to help this process by faxing or emailing a consent form to your primary healthcare provider.

General Information

Massage therapy is not intended to replace prenatal or postpartum care. Used as a form of adjunctive healthcare, potential benefits are:

During pregnancy

- Reduces stress, promotes relaxation and facilitates transitions through emotional support and physical nurturing.
- Reduces negative effects of circulatory system changes, including edema, varicose veins and increased blood pressure.
- Minimizes discomforts of pregnancy's hormonal, respiratory, gastrointestinal, urinary and other physiological adaptations.
- Reduces musculoskeletal strain and pain.
- Develops the flexibility and kinesthetic awareness necessary to actively participate in the birth process.
- Fosters nurturing maternal touch and healthy bonding.

In labor

- Contributes to shorter, less painful labor.
- Reduces labor complications, medications and interventions.
- Improves infant well-being, mother's satisfaction with the birth and family formation.

In the postpartum period

- Facilitates postpartum emotional, physiological and family adjustments.
- Reduces musculoskeletal and organ pain.
- Promotes structural realignment of the spine and pelvis, and reorganization of movement.
- Contributes to rehabilitation of abdominal skin, muscles and organs.



- Promotes recovery from Cesarean birth, including healing of the incision.
- Relieves muscle strain and tension caused by childcare activities.

Across society

- Develops individuals more capable of love and pleasure.
- Builds less violent, more respectful cultures.

Pregnancy massage is usually beneficial throughout pregnancy, labor and postpartum. If you have or have had any of the high-risk factors, complications, or conditions listed below, discuss your condition with your physician or prenatal healthcare provider. Submit the included consent at or prior to your first appointment.

Postpartum massage therapy can begin 24 hours after giving birth. If there were complications or a cesarean birth, you must have written consent from your physician or prenatal healthcare provider if you wish to receive massage therapy in the first six weeks postpartum or if you are still under your physicians care for this pregnancy.

High-risk Factors and Complications (Please check any that apply to you)

- Age (younger than 15 or older than 35)
- Asthma or other pulmonary condition
- Chronic hypertension or gestational hypertension
- Diabetes and/or gestational diabetes
- Anxiety, depression or other mental health condition
- Autoimmune disease
- Bedrest required
- Birth complication
- Cardiovascular disease
- Cesarean birth (planned or post-cesarean)
- Fetal development/movement complications
- Genetic disorder/DES exposure/uterine
- Inadequate support system or abuse
- Infection (COVID-19, sexually transmitted or other viral and/or bacterial disease)
- Kidney, liver and/or bladder disorder
- Multiple gestation pregnancy
- First pregnancy
- 4th or more pregnancy
- Previous complications of pregnancy
- Placental or uterine dysfunction or abnormality



- Renal/liver/blood/convulsive disorders
- Rh negative
- Severe varicose veins and/or thrombophlebitis
- Severe nausea
- Thyroid disorder
- Tobacco or other substance abuse
- Threatened miscarriage or prematurity
- Post-date pregnancy
- Other

Details regarding above:

Other health concerns (Please check any that apply to you)

- Cancer or undiagnosed lumps
- Skin irritation and/or discharge
- Fracture, bleeding, burns or other acute injury

Details regarding above:

To: _____ (*Massage Therapist*)

Re: *Consent to Receive Prenatal/postpartum Massage Therapy*

I verify that I have been informed of the possible benefits and the contraindicated conditions for massage therapy during pregnancy and postpartum. I have discussed with my physician/ prenatal healthcare provider any health concerns that I have about massage therapy for me and my baby/babies. I further verify that: (check one)

I have not had nor do I now have any prenatal complications nor any of the conditions listed above.

I have noted above all prenatal/postpartum complications, risks, or conditions I am experiencing/have experienced AND I have obtained my maternity healthcare provider's consent to proceed.



I understand that I will be receiving massage therapy and bodywork as a form of adjunctive health care only and that the massage therapy I receive is not a substitute for maternity prenatal or perinatal care from a medical doctor or other licensed provider.

I give my consent for you to confidentially consult with the above provider about our work and my condition as needed to coordinate quality care for me and my baby/babies.

I hereby release and hold harmless and defend the massage therapist from any claims, liability, demands and causes of action arising from my and my child's participation in this therapy.

Signature: _____ Date: _____ Print Name: _____

HEALTH CARE PROVIDER'S CLEARANCE FOR MASSAGE THERAPY DURING PREGNANCY/POSTPARTUM

To: _____ (Massage Therapist)

_____ (Pregnant Client's Name) is under my supervision for prenatal health care. Her pregnancy is progressing normally. Therapeutic massage would, in my opinion, be an acceptable form of adjunctive care during her pregnancy. I have listed below any limitations in massage procedures relevant for her:

(Signature) _____, prenatal health care provider

(Print name) _____

(Phone) _____

(Email) _____

(Date) _____



PHYSICIAN'S CLEARANCE FOR THERAPEUTIC MASSAGE/BODYWORK DURING PREGNANCY AND/OR POSTPARTUM

Your patient, _____ (Patient's Name), has requested prenatal/postpartum therapeutic massage. These services are provided as adjunctive health care. When an individual's pregnancy is high risk, or she has experienced complications or contraindicated conditions, it is our policy to work with her only if her maternity medical provider has reviewed this request. Please verify your clearance of this request with your signature below. Please also list any precautions or limitations which you feel to be appropriate. Thank you for your assistance.

Limitations: _____

(Signature) _____, physician

(Print) _____

(Phone) _____

(Email) _____

(Date) _____