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**GP Clearance Form**

*Please either print or email this completed form to your GP or consultant or telephone your surgery to obtain verbal consent based on the below information:*

Dear Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Re: Client Name / Date of Birth / Address [client to add info here]**

My client would like to attend for the following treatment/s and as per conditions of my professional association, the Federation of Holistic Therapists, I need to ask if there is any reason why their treatment should not go ahead.

**Section 1: To be completed by the client [mark the treatment you are having].**

|  |  |
| --- | --- |
| **Mark All Applicable** | **Treatment Type & Description – 45 Minute Sessions** |
|  | **Reflexology:** By applying specialised massage techniques to specific reflex points - using the thumbs, fingers and knuckles – the aim of a reflexology treatment is to help restore balance to the body naturally, and improve the client’s general well-being.  More information: [www.fht.org.uk/therapies/reflexology](https://www.fht.org.uk/therapies/reflexology) |
|  | **Massage:** Massage involves working the soft tissue of the body, to ease day-to-day stresses and muscular tension, and promote relaxation.  More information: [www.fht.org.uk/therapies/body-massage](https://www.fht.org.uk/therapies/body-massage) |

**Reason for visit [Delete as applicable]:** Pain, Tension, Stress, Mood, Wellbeing, Other

**Section 2: To be completed by the client**

My client is in the clinically vulnerable (moderate risk group) for COVID-19 and meets the following criteria [mark all that apply]:

|  |  |
| --- | --- |
| **Mark if Yes** | **Condition** |
|  | is 70 or older |
|  | has a lung condition that's not severe (such as asthma, COPD, emphysema or bronchitis) |
|  | has heart disease (such as heart failure) |
|  | has diabetes |
|  | has chronic kidney disease |
|  | has liver disease (such as hepatitis) |
|  | has a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy) |
|  | has a condition that means they have a high risk of getting infections |
|  | is taking medicine that can affect the immune system (such as low doses of steroids) |
|  | is very obese (a BMI of 40 or above) |

**Section 3: To be completed by the Client [if applicable]**

My client has had COVID-19 and was extremely/moderately/slightly unwell [delete as applicable]. I am aware this can lead to future health complications.

**Section 4: To be completed by the GP/Consultant**

GP/Consultant to confirm if the treatment should proceed [mark the relevant box]:

|  |  |
| --- | --- |
|  | YES – I do not see any reason why their treatment should not go ahead |
|  | NO – the patient should not have a treatment at this stage |

I am a professional therapist who is qualified and insured and listed on the FHT’s [Accredited Register](https://www.fht.org.uk/about-the-fht-complementary-healthcare-therapist-register) of complementary therapists independently approved by the Professional Standards Authority. As a registered practitioner I have demonstrated that I meet UK wide standards and abide by a rigorous code of conduct. Further information about my practice is available by visiting my website: [www.roseholistictreatments.co.uk](http://www.roseholistictreatments.co.uk).

Yours sincerely

Anne-Marie Rose ITEC, IIHHT, MFHT

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Description automatically generated