



Galter LifeCenter Consent for Watsu Aquatic Therapy Program

Date: _____

Dear Health Care Provider:

1. Your Patient _____ wishes to begin receive Watsu Aquatic Therapy from a licensed Occupational Therapist and/or licensed Massage Therapist within the Integrative Therapies Department at Galter LifeCenter.

2. Does your patient have a current medical diagnosis (please circle)? YES NO

If YES please specify diagnosis and any precautions and or modifications that are required for your patient to participate in the Watsu Aquatic Therapy.

3. If your patient is taking any medications, please indicate the type of medication below and the effect it may have on your patient during passive stretching in a warm water (94-96 degree) aquatic environment. Type of Medication and Effects:

4. The above-mentioned patient has my approval to receive Watsu Aquatic Therapy at Galter LifeCenter under the supervision and treatment of a licensed Occupational Therapist and/or licensed Massage Therapist with the recommendations and or restrictions above, if any.

Date: _____ Phone: _____

Health Care Provider's Signature

Printed Name

***Please Fax to 773-878-1173 ATTN: Integrative Therapies Supervisor**

If you have any further questions regarding the Watsu Aquatic Therapy Program please contact Galter's Watsu Aquatic Therapists at 773-878-9936, Ext. 3122.