

# Complimentary Therapy Checklist & Consent

If you receive a call while on duty from someone enquiring about Complimentary Therapies, please carry out the following:

## 1. REFERENCES & DEFINITIONS

East Galway & Midlands Cancer Support: EGM

EGM-MA-01 Master List of Policies and Procedures

## 2. IMPLEMENTATION

Ask the Client to specify what therapy they are interested in?

Take their contact details (Name, Address, Mobile Number and Email Address)

Ask them if they are on treatment, and, if they are, inform them that they must have at least one session of Chemotherapy completed before we can allow therapies.

Inform them that they will need to get a consent form signed by their GP, if not on active treatment, or, from their Medical Oncologist, if undergoing treatment.

Ask them to call to the Centre during opening hours to collect the Consent Form to be signed and either return it to us or ask their GP to return it. Alternatively, a Consent Form can be sent out to them in the post.

Inform them that once the Consent Form is returned, the Director of Services may contact them to discuss appropriate therapies and arrange an appointment.

Pass all this information to the Director of Services.



**Tel: (090) 964 2088**

**[www.egmcancersupport.com](http://www.egmcancersupport.com) | E: [info@egmcancersupport.com](mailto:info@egmcancersupport.com)**

**Brackernagh, Ballinasloe, Co. Galway H53 P8H0**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street: \_\_\_\_\_

Town: \_\_\_\_\_

County: \_\_\_\_\_

Eircode: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

I.C.E Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_

Are you receiving active treatment? Yes  No  If so, what type? \_\_\_\_\_

To be completed by an Oncologist, if you are currently undergoing treatment, otherwise a GP's consent will suffice.	
Oncologist	GP
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone Number: _____	Phone Number: _____
Registration Number: <sup>1</sup> _____	Registration Number: <sup>1</sup> _____
Signature: _____	Signature: _____
Date: _____	Date: _____
I, the above-named Oncologist / GP, agree that the client is a suitable candidate for the Complimentary Therapies, as shown below, offered by East Galway & Midlands Cancer Support	
Bio Energy <input type="checkbox"/> Chiropody <input type="checkbox"/> Counselling <input type="checkbox"/> Nutrition <input type="checkbox"/> Healing Touch <input type="checkbox"/> Massage <input type="checkbox"/> Indian Head Massage <input type="checkbox"/> Fitness Programme <input type="checkbox"/> Reflexology <input type="checkbox"/> Reiki <input type="checkbox"/> Mindfulness <input type="checkbox"/>	
For Office Use Only (To be completed by an Administrator)	
EGM Reference #: _____	
Date Consent Form Received: _____	
Therapist/s Notified: _____	
1 <sup>st</sup> Appointment Date: _____	

<sup>1</sup> Registration Number is the number you received from the Medical Council of Ireland



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