Interdisciplinary Notes

MASSAGE THERAPY

DATE / LOCATION /
THERAPIST NAME

MASSAGE #

Y	N	Checked in with RN prior to massage	**Observed / reported**	**Massaged**	**Application**	**Duration**
Y	N	Patient in treatment for active VTE	☐ Edema	☐ Feet	☐ (0) Weightless	☐ > 5 min
Y	N	Patients first hospital-based massage	☐ Thrombocytopenia	☐ Lower legs	☐ (1) Light	☐ 5-10 min
Y	N	Language barrier	☐ Skin / nail conditions	☐ Hands	☐ (2) Gentle	☐ 10-15 min
Y	N	Used lotion	☐ Nausea	☐ Lower arms	☐ (3) Medium	☐ 20 min
Y	N	Used acupressure points / reflexology	☐ Anxiety / fatigue	☐ Shoulders / neck	☐ (4) Strong	
Y	N	Used aromatherapy	☐ Pain / neuropathy	☐ Head / face	☐ (5) Deep	
Y	N	Provided program feedback form or oncology massage information for patient or patient companion				

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