

**Informed Consent
Anterior and/or Lateral Chest Massage
for male and female clients**

CONFIDENTIAL
Additional CONSENT
FORM

This form is to be used in conjunction with the standard informed consent document

The region of the anterior and lateral chest is considered a sensitive area. It is a region that is considered high risk for misunderstandings. Your therapist must collect a full health history from you and complete a thorough and full consultation on your first visit. For subsequent visits, your therapist must review your health history form with you to ensure they are current with your health situation.

Massage of the anterior and lateral chest is often included as part of the massage sequence taught by a Registered Training Organisation (RTO). It is also included in specific modalities, at a higher level of education, to address specific musculoskeletal and lymphatic disorders as well as in traditional Eastern sequences.

If your therapist recommends massage of your anterior and/or lateral chest as part of your treatment today, they are required to follow *guidelines* to protect both you and them. Full verbal and signed written consent must be obtained from you following your therapists full explanation of **why** an anterior chest and / or lateral chest massage is required in the treatment session, **before** the treatment session begins.

The techniques recommended by your therapist should only be applied if your therapist has the relevant qualification in the specific modality, or is competently trained with the various remedial techniques learned in the Health Training curriculum in Australia. You are entitled to request to view evidence of your therapists qualifications.

Any of the following techniques may be recommended to you in your treatment. The therapist will tick that which applies to your treatment today.

- | | |
|--|--|
| <input type="checkbox"/> Kahuna Bodywork or Lomi Lomi | <input type="checkbox"/> Lymphoedema Management |
| <input type="checkbox"/> Manual Lymphatic Drainage (MLD) | <input type="checkbox"/> Muscle Energy Techniques (MET) |
| <input type="checkbox"/> Myofascial Release Techniques (MFR) | <input type="checkbox"/> Positional Release Techniques (PRT) |
| <input type="checkbox"/> Post-surgical procedures | <input type="checkbox"/> Remedial Massage Therapy |
| <input type="checkbox"/> Trigger Point Therapy (TrPT) | |

Anterior and lateral chest treatment will be most effective when it is preceded by the relaxation of surrounding muscles. This refers to the pectoralis major and pectoralis minor muscles in particular, but other muscles in the region that can refer pain to either the anterior chest or lateral chest may be treated. Please refer to the 'Client Information – anterior and lateral chest massage' brochure provided by your therapist.

Referral

If you have a referring practitioner for anterior and/or lateral chest massage please provide their details below.

Name: _____

Address: _____

Phone: _____ Post Code: _____

Surname

First Name

Consent:

- The therapist clearly explained to me why they have reached the decision to include an anterior and/or lateral chest massage in my treatment today
- The therapist has explained why I would benefit from receiving treatment to the anterior and/or lateral chest region
- The therapist has explained the treatment techniques they will use. Should the therapist require to modify the treatment in any way, they will stop the treatment and explain their reasons with me
- The therapist has explained the associated risk and possible side effects with this treatment and any potential risks or outcomes if the treatment is changed
- The therapist has explained to me how I will be laying on the table during treatment of the anterior and/or lateral chest region
- The therapist has explained how I will be draped (covered) during treatment of the anterior and/or lateral chest region
- The therapist took comprehensive notes throughout the consultation
- The therapist has provided me with the relevant policy and guidelines and the appropriate education leaflets or brochures to help explain the process and selected treatment modalities

Please note the possibility that a massage of the anterior and/or lateral chest may invoke emotional reactions or painful memories

Under no circumstance is the nipple or areola to be touched or intentionally stimulated regardless of the gender of the client

Terms and Conditions

- I understand that by signing this form I consent to the treatment plan proposed today
- I am 18 years of age or older
- I am the guardian / carer of the client and consent to the treatment plan proposed. I shall remain in the room throughout the treatment session
- I have provided consent to treatment voluntarily
- I am of sound mind and am not influenced in any way
- I verify that the client information and medical history I have provided is, to the best of my knowledge, true and accurate. I undertake to advise the therapist of any changes that may occur in any of my conditions at any future massage treatment
- I hereby give my consent to anterior and / or lateral chest massage treatment for this session.

Signature: _____ **Date:** _____

Your therapist will file this consent form with your client notes. Your therapist will provide a consent form for **every** treatment you receive. Consent for anterior and lateral chest massage will be required prior to every session and documented accordingly.

Complaints:

Your therapist is a member of Massage & Myotherapy Australia – the Professional Association for Massage Therapists and Myotherapists. If you are unhappy with any aspect of the treatment you receive, Massage & Myotherapy Australia has in place a formal process for the public, or membership, to raise any complaint in relation to therapist / client inappropriateness or unprofessionalism.

Please call the office 1300 138 872 if you wish to make a complaint or for any information in regard to the process for massage treatment of the anterior and/or lateral chest.