# Neurologist Release for Special Programs

ACT *for* MS requests that you have your Neurologist fill out this form before you can participate in any of our therapy programs. We also request that your Neurologist confirms your diagnosis of MS on his/hers letterhead/prescription pad.

It is with my complete consent that _____ (patient's name) begins:

| | |
|---|---|
| _____ Massage or Reflexology | Maximum of 2 one-hour sessions every month. |
| _____ Exercise Therapy | Maximum of 2 one-hour sessions per week. |
| _____ Aquatic Therapy | Maximum of 1 session per week |
| _____ Yoga Therapy | Maximum of 1 session per week |

Print Neurologist's Name: _____

Neurologist's Signature: _____

Date: _____

Neurologist's Notes: _____

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