Referral for Adjunctive Hypnotherapy Sessions

Dear Licensed Medical or Psychotherapeutic Practitioner ("Licensed Practitioner"):

Patient name: _____

I am a Certified Hypnotherapist practicing in *Sanctuary Cove* and also via telephone *(if applicable).*

The subject patient has sought my services for the following issue(s):

Because of the possible medical or psychotherapeutic nature of these issues, I am required to obtain a professional referral for hypnotherapy.

The nature of my hypnotherapeutic services is motivation and behaviour modification, and I also teach relaxation and visualization techniques.

These services are not intended to be therapeutic in any way except by the referral of a Licensed Practitioner, or to interfere with any appropriate medical or psychotherapeutic care required by the patient.

Upon request and the patients consent (please check the box below) I will apprise you as to the patient's progress.

For more information please see my website *www.gchypnotherapy.com.au*

Phone: *0477 650 000*
Email: *jade@gchypnotherapy.com.au*
Web: *www.gchypnotherapy.com.au*
Address: *The Sanctuary Cove Country Club*
Treatment Room 3
1 Gleneagles Drive
Sanctuary Cove QLD 4212

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Statement of Licensed Practitioner:

I have evaluated this patient, and concur with the use of hypnosis for the stated areas. I provide the following special notes or instructions:

In my professional opinion, hypnotic sessions may be of aid or value as an adjunctive technique for habit reconditioning or self-improvement in this case, and for the above purposes I refer the client to you for hypnosis sessions. There is nothing that would preclude the use of hypnotic techniques in this case.

Please provide contact information for the Licensed Practitioner:

Name: _____

Phone: _____

Email: _____

Send updates about this patient ☐

Address: _____

Specific Instructions or Precautions if applicable:

☐ Smoking Cessation	☐ Pain Management
☐ Weight Management	☐ Irritable Bowel Syndrome
☐ Diabetes Management	☐ Fibromyalgia
☐ Anxiety	☐ Migraine Headache
☐ Insomnia / Sleep Disorder	☐ Epilepsy
☐ Phobia	☐ Other please specify:

Sign: _____ Date:_____

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