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

Sign: ____________________________ Date:___________