# PRACTICE NAME

*HYPNOTHERAPY*

Any Name, CHt
Office Street Address
Any Town, State Zip Code
Area Code/111-1111
Fax: Area Code/ 222-2222
Email.com
www..com

Date of Referral________________________________

Referring Dr. Name______________________________

Address______________________________

Phone______________Fax______________

Patient Name________________________________

Complementary Therapy Prescription For:

____Smoking/Tobacco Cessation

| | |
|---|---|
| ____Weight Release | ____Stress Management |
| ____Fear Management | ____Pain Management |
| ____Addictions | ____Insomnia |
| ____Pre surgery | ____Allergies |
| ____Post Surgery | ____Dental________________ |

____Disease Management (DX Code____________________)

____Other______________________________

Referring Doctor's Instructions, Comments and Treatment Goals:

________________________________________________

________________________________________________

________________________________________________

________________________________________________

Doctor's Signature________________________________

**MAP TO OFFICE ON REVERSE SIDE**

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