

# Ocotillo Hypnosis

## PATIENT REFERRAL FORM

Date: \_\_\_\_\_

### Patient Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Physician Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I have examined \_\_\_\_\_ and see no contraindications in using hypnosis and hypnotic suggestion to treat this patient for \_\_\_\_\_.

I have the following additional information and instructions for you: \_\_\_\_\_

Please keep me informed as to my patient's progress.

Signature: \_\_\_\_\_