Medical Referral Form

Dear Physician, Date: _____

I am interested in obtaining hypnosis service from the staff of:

Help Heal Yourself
3 Bonney Lane
Hampton, VA 23669
Phone: (757) 275-4006 (Mario)
Phone: (757) 239-0791 (Ruth)
www.HelpHealYourself.net

To help relieve the following symptoms, problems or conditions:

_____
_____
_____
_____

My hypnotist requires this form prior to my first appointment on _____, indicating that my health care professional is aware of my desire to use hypnosis and to avoid masking any symptoms before a proper medical diagnosis has been made and/or necessary medical treatment administered.

Patient/Client Signature _____

Printed Name: _____ Date of Birth: _____

PLEASE RETURN SIGNED FORM TO:

Help Heal Yourself
3 Bonney Lane
Hampton, VA 23669
Email: mwgrimes@hotmail.com

I am aware of my above referenced patient's desire to use hypnosis to help with his/her above listed symptoms and/or to promote wellness and have no objection.

My patient has the following diagnoses: _____
_____
_____
Additional Comments or instructions: _____
_____

Physician's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____