AVALON
HYPNOSIS CENTER

Clinical / Physicians Referral Foam

Date:_____

Patient Info:

Patient Name: _____ Phone: (_____) _____

Address: _____ City: _____ State:_____ Zip: _____

Email Address: _____

Physician Info:

Physician Name: _____ Phone: (_____) _____

Address: _____ City: _____ State:_____ Zip: _____

Email Address: _____

Physician Release & Approval:

Since we require a physician's referral in some cases we would appreciate your signature indicating your approval. Please be assured that I shall keep you informed as to your patient's progress.

I understand that my patient _____
wishes to undergo hypnosis for the following purpose:

_____

_____

I have examined this patient and see no contradiction to the use of hypnosis and hypnotic suggestions in this case. I have these additional comments and instructions:

_____

_____

_____

Physicians Signature:_____ Physician # _____

Print Physicians Name: _____ Date: _____

AVALON HYPNOSIS | 300 N. Ronald Reagan Blvd. Suite 301, Longwood, FL 32750
Katheryn Napier, Certified Senior Hypnotist | Katheryn@AvalonHypnosis.com
(407)-492-7363 | www.AvalonHypnosis.com