Hypnotherapy Referral for Pain Management

I authorize hypnotherapy for pain management for my patient ____

who suffers from pain located in his/her ____.

That has been diagnosed as ____.

Hypnotherapy for pain management is limited to____

____ Parts of the body.

Doctors Name ____

Degree ____

Practice /Work Address ____

____

City ____________________________Country_____________________________________

Phone ____

Email ____

__________________________________ Doctors Signature

__________________________ Date MM/DD/YY