A New You
CENTER FOR HYPNOSIS LLC

Hypnosis Referral Form

Patient Name: _____ DOB: _____

Diagnosis: _____

Specific Instructions or Precautions: _____

_____

_____

_____

_____

- ❑ Smoking Cessation
- ❑ Weight Management
- ❑ Diabetes Management
- ❑ Anxiety
- ❑ Insomnia / Sleep Disorder
- ❑ Phobia
- ❑ Pain Management
- ❑ Irritable Bowel Syndrome
- ❑ Fibromyalgia
- ❑ Migraine Headache
- ❑ Erectile Dysfunction
- ❑ Other

Referring Provider (Print): _____ Date: _____

Signature: _____ Phone: _____

Please mail to:

A New You Center For Hypnosis LLC
Attn: Ed Lane, BCH
3 Webb Place, Suite 4
Dover, NH 03820