



MIND MATTERS®  
HYPNOSIS CENTER, LLC

Date:  
Drs Name:  
Address:

Dear Dr:

Your patient \_\_\_\_\_ wishes to undergo hypnotic conditioning and suggestion for issues related to: \_\_\_\_\_

Since we require a medical referral in such cases, we would appreciate your signature below indicating your approval. Please be assured that we will keep you informed of your patient's progress.

Thank you for your kind attention.

Sincerely,

Monica Katzen, CCH, MA  
Certified Consulting Hypnotist  
Mind Matters Hypnosis Center  
50 Albany Turnpike  
Suite 5  
Canton, CT 06019  
Phone (860) 693-6448  
Fax (860) 693 2221

**For the Physician**

I have examined \_\_\_\_\_ and see no contraindication to the use of hypnosis and hypnotic suggestion in this case.

I have these additional comments and instructions for you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. \_\_\_\_\_  
Signature

Physician name, address: (Please print or type)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_