



Client Referral for Mind-Body Coaching & Hypnosis Services

Date: _____

Patient/Client Name: _____

Dx (Diagnosis / Reason for Referral / Goals): _____

Please provide this client with support in the following areas:

- ☐ Stress / Anxiety Management
- ☐ Habit Change (Smoking, Eating, etc.)
- ☐ Performance (Sports / Academic / Professional)
- ☐ Confidence / Mindset
- ☐ Sleep Improvement
- ☐ Pain Management Support
- ☐ Focus & Attention Support
- ☐ Emotional Processing / Past Events
- ☐ General Wellness
- ☐ Other: _____
- ☐ Patient/Client consents to communication between provider and CCH if needed.

Referring Provider Name: _____

Practice Name: _____

Phone/Email: _____

Signature: _____

Certified Consulting Hypnotist | EFT Practitioner | Mind-Body Coaching

This service is complementary and does not replace medical or psychological care.

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