



**HELP from WITHIN  
+ HYPNOSIS +**

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www.HELPfromWITHIN.com

9330 Regency Park Boulevard + Port Richey, Florida 34668 + 727-848-1535 Fax: 727-848-2404

**PRESCRIPTION REQUEST: HYPNOSIS for THERAPEUTIC PURPOSES**

**TO** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Your patient,** \_\_\_\_\_, wishes to use hypnosis for therapeutic purposes to:

- Control:     Change     Distract     Eliminate     Maintain     Reduce/Relieve
- Empower :     Develop     Enhance     Energize     Strengthen/Heighten     Prevent

**Due to challenge(s) in :**

- Activity demands \_\_\_\_\_
- Body functions/structures/systems \_\_\_\_\_
- Context: Time/Cultural/Social/Spiritual \_\_\_\_\_
- Mental/Physical/Sensory \_\_\_\_\_
- Motor/Process/Communication \_\_\_\_\_
- Performance: ADL/IADL/Work/Play/Leisure \_\_\_\_\_
- Skills: Habits/Roles/Routines: \_\_\_\_\_

He/she has expressed a clear intention and belief that desired outcomes will be achieved. These two important motivational factors are essential factors for success. Hypnotic techniques are determined based on a person's personality, personal, medical histories, and specific session objectives. Common hypnotic techniques include and are not limited to, any of the following:

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Anchoring            | <input checked="" type="checkbox"/> Integrate Polarities               | <input checked="" type="checkbox"/> Self-hypnosis training  |
| <input checked="" type="checkbox"/> Cognitive-Behavioral | <input checked="" type="checkbox"/> Metaphors                          | <input checked="" type="checkbox"/> Stimulate immune system |
| <input checked="" type="checkbox"/> Deep breathing       | <input checked="" type="checkbox"/> Mind-Body                          | <input checked="" type="checkbox"/> Suggestions             |
| <input checked="" type="checkbox"/> Deepening            | <input checked="" type="checkbox"/> Neuro Linguistic Programming (NLP) | <input checked="" type="checkbox"/> Time Distortion         |
| <input checked="" type="checkbox"/> Desensitization      | <input checked="" type="checkbox"/> Post-hypnotic suggestions          | <input checked="" type="checkbox"/> Visualization           |
| <input checked="" type="checkbox"/> Dissociation         | <input checked="" type="checkbox"/> Regression                         | <input checked="" type="checkbox"/> Other: _____            |
| <input checked="" type="checkbox"/> Guided imagery       | <input checked="" type="checkbox"/> Relaxation training                |   |
| <input checked="" type="checkbox"/> Follow up tasks      | <input checked="" type="checkbox"/> Role playing                       |   |
| <input checked="" type="checkbox"/> Inductions           |  |   |

We request your written prescription, direction and supervision to initiate hypnosis for therapeutic purposes. Your insight and guidance is greatly valued. Please be assured you will be apprised of your patient's progress. Indicate your decision by completing the attached **"HYPNOSIS FOR THERAPEUTIC PURPOSES PRESCRIPTION."** When completed, fax to HELP from Within HYPNOSIS, attention Dr. Vanessa M. Dazio, FAX # 727-848-2404.

Sincerely,

Vanessa M. Dazio, OTD, OTR/L, NBCCHT, C.Ht.  
National Board: Certified Clinical Hypnotherapist  
Doctor of Occupational Therapy  
Nationally registered and FL Licensed (# 1084)



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**PRESCRIPTION: HYPNOSIS FOR THERAPEUTIC PURPOSES**

**Date:** \_\_\_\_\_

**My Patient: (NAME)** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Precautions:** \_\_\_\_\_

**Contraindications:** \_\_\_\_\_

**PRESCRIPTION: Please check (√) one answer.**

**I DO** approve and authorize this prescription for hypnotic techniques for therapeutic purposes, as an adjunct supportive and complementary medical service to maximize my patient's health and wellness. I am willing to provide supervision and direction as needed throughout the hypnotic programming.

The certified clinical hypnotherapist may choose the most appropriate hypnotic techniques based on my patient's personality, personal and medical histories, specific session objectives, and my patient's comfort level and personal approval of the intended hypnotic programming.

**I DO NOT** authorize the use of hypnotic techniques for this patient, at this time, due to medical contraindications.

**OTHER: Please check (√) applicable instructions**

Call my office extension: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ to discuss intended hypnotic programming.

Call my cell phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ to discuss intended hypnotic programming.

Please provide copy of written progress notes and final summary

Please provide copy of final written summary only

Other

comments/instructions: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Referring Practitioner**

\_\_\_\_\_  
**Date of Authorization for Hypnosis**

\_\_\_\_\_  
**Print Name**

\*\*\*\*\*

**FOR HELP FROM WITHIN OFFICE ONLY**

\_\_\_\_\_  
**HFWH Representative**

\_\_\_\_\_  
**Date Rec'd/Recorded/Notified at HFWH**