Hypnosis Referral Form

Referred by:______________________Patient Name:__________________________________

Medical Diagnosis (ICD-10):____

1. Is this individual age 18+, with chronic pain or pain for at least 3 months, and able to read, write, and understand English? (if YES, proceed)

2. Does this patient have any of the following (if YES to any of the items below, patient is not appropriate for this group):

☐ Cognitive Impairment/Limitations?

☐ Current or history of a psychotic or major thought disorder?

☐ Any past psychiatric hospitalizations for reasons other than SI/HI or PTSD in the past 5 years?

☐ Current unstable or severe psychiatric or behavioral conditions? Or past issues participating in groups?

☐ Active suicidal ideation or acute emotional distress?

☐ Take 120mg of Morphine or Morphine Equivalent Dose per day?

3. Please ask the patient the following questions and indicate the response below:

- What is your average pain intensity in the past week, with "0" being no pain and "10" being the worst pain imaginable? ______
- What has been your worst pain in the past week, with "0" being no pain and "10" being the worst pain imaginable?_______
- Which statement best describes you:
  - A) I have pain all of the time
  - B) I have pain most of the time
  - C) My pain comes and goes
  - D) I have occasional pain
- How long have you been experiencing pain? _____________________

Is the patient interested in possibly participating in the research associated with this treatment? ☐ YES ☐ NO

If yes, best # to contact:_______________________________________

Email: ____

Date of IRB Approval: 01/12/2018

Institutional Review Board