ADULT REFERRAL FORM

Patient Information

First Name: ______________________ Last Name: ______________________
DOB: ______________________ Health Card Number: ______________________
Cell Phone: ______________________ Home Phone: ______________________
Email: ______________________

Referring Clinician Information

First Name: ______________________ Last Name: ______________________
Registration Number: ______________________
Address: ______________________
Phone Number: ______________________ Fax Number: ______________________

☐ Physician ☐ Psychologist ☐ Social worker ☐ Nurse practitioner
☐ Physiotherapist ☐ Other: ______________________

Reason for Referral

☐ Insomnia
☐ Snoring
☐ Sleep apnea
☐ Excessive sleepiness
☐ Depression
☐ Anxiety
☐ Unusual behaviour in sleep
☐ Possible narcolepsy
☐ Nightmares
☐ Sleep problems after a concussion
☐ Possible body clock problem (e.g. unusual sleeping time, shift work)
☐ Other mental health issues – please describe: ______________________
☐ Fatigue related to medical conditions – please describe: ______________________
☐ Other – please describe: ______________________

Specific referral for:

☐ Sleep assessment
☐ Cognitive behavioral therapy for insomnia
☐ Individual psychotherapy for mental health issues
☐ Post-concussion sleep assessment and treatment
☐ Fatigue management
☐ Sleep apnea evaluation
☐ Nightmare therapy
☐ Melatonin testing
☐ Combined Psychotherapy and Bright light therapy
☐ Narcolepsy assessment/treatment
☐ Narcolepsy group
☐ Sleep-related medico-legal assessment
☐ Fitness to drive evaluation
☐ Psychotherapy to help coping with medical conditions or chronic pain
☐ Education about sleep apnea and/or psychotherapy to help to adhere to sleep apnea treatment
☐ Education and psychotherapy for sleep walking or other unusual behavior in sleep