SLEEP ON THE BAY

PEDIATRIC AND ADOLESCENT 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: _____

Referral for:

☐ Melatonin Assessment
☐ Evaluation of potential body clock problems (e.g. unusual sleep time in teenagers)
☐ Sleep evaluation and sleep treatment in ADHD
☐ Sleep evaluation and sleep treatment in Fetal Alcohol Spectrum Disorders
☐ Sleep evaluation and sleep treatment after a concussion
☐ Sleep evaluation and sleep treatment in depression
☐ Sleep evaluation and sleep treatment in Autism Spectrum Disorders
☐ Sleep evaluation and sleep treatment in Prader-Willi Syndrome

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