SLEEP ON THE BAY

SELF-REFERRAL FORM

Your Information

First Name: _____ Last Name: _____
Phone: _____ Email: _____

I am looking for help for:

☐ Insomnia (difficulties with falling asleep/staying asleep)
☐ Snoring
☐ Sleep apnea
☐ Excessive sleepiness
☐ Possible body clock problem (e.g. unusual sleeping time)
☐ Sleep problems after a concussion
☐ Unusual behaviour in sleep
☐ Nightmares
☐ Depression
☐ Anxiety
☐ Other mental health issues – please describe: _____
☐ Fatigue related to medical conditions – please describe: _____
☐ Other – please describe: _____

I am specifically interested in:

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

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