Patient Referral Form

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Patient Information

First Name: _____ Last Name: _____

D.O.B.(dd/mm/yy): _____ Primary Phone Number: _____

Email: _____

☐ Patient is over 18 years of age and resident of Ontario or Nova Scotia and is aware of that services are delivered via Telehealth

Reason(s) for Referral

Sleep

- ☐ Insomnia (CBT for Insomnia CBT-I)
- ☐ Sleep Anxiety
- ☐ Nightmares
- ☐ Sleep Medication discontinuation
- ☐ Hypersomnia
- ☐ Circadian Rhythm problems
- ☐ CPAP Desensitization

Mental Health

- ☐ Anxiety (GAD, Panic, Phobias, Social, Health)
- ☐ Stress Management /Burnout
- ☐ Depression
- ☐ Adjustment issues
- ☐ Other (please specify):

For SLEEP referrals:

Previous in-lab sleep study? ☐ Yes ☐ No
(If yes, please attach results)

- ☐ Sleep Apnea ☐ Treated ☐ Untreated
- ☐ Restless Leg Syndrome ☐ Treated ☐ Untreated
- ☐ Narcolepsy
- ☐ Other sleep disorder(s): _____
- ☐ Concussion (in the last 3 months)

*Does the patient have any of the following conditions?

☐ Bipolar ☐ Seizures ☐ High risk of falls
☐ Unstable Mental Health condition ☐ Suicidal

*(Please note, these conditions are not suitable for CBT-I sleep restriction)

Additional Information

Duration of Problem: _____

Relevant Medical/Psychiatric History:

Other Relevant Information:

Current Medications and Supplements:

Substance Use: ☐ Yes (please specify) ☐ No

Referring Healthcare Provider

Provider Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Specialization: _____ Facility: _____

Provider Signature: _____ Date (dd/mm/yy): _____

[Please Fax all referrals to 905-798-6098]