INSOMNIA HELP CANADA

Patient Referral for Cognitive Behavioural Therapy for Insomnia

Patient Name: _____ Date of birth: _____

Parent / Guardian Name (if pediatric referral): _____

Address: _____

Phone #: _____ Alternate phone #: _____

* Okay to leave a confidential voice message? Yes ❑ No ❑

Insomnia History

When did insomnia start? _____ # of nights / week [average]? _____

Comorbid Sleep Disorders

Sleep Apnea: Diagnosed _____ Suspected _____ AHI: _____

Is the patient interested in exploring assessment and treatment of other possible sleep disorders?

- ❑ Circadian Rhythm Disorder: Diagnosed _____ Suspected _____
- ❑ Shift Work Disorder: Diagnosed _____ Suspected _____
- ❑ Nightmare Disorder: Diagnosed _____ Suspected _____
- ❑ Other possible sleep disorder / Please specify: _____

Other comments: _____

Referring Physician / Provider Name & Contact Info: _____

_____

To receive a progress report, please provide patient Consent for Release of Information.

Please fax to: 1-604-876-5889

lorraine@insomnia-help.net | insomnia-help.net | 1-888-876-8954