INSOMNIA HELP CANADA

Patient Referral for Cognitive Behavioural Therapy for Insomnia

Patient's Name: _____ **Date of birth**: _____

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 sleep apnea currently being treated successfully? [≥ 4 hours/night, 5 nights/week]

- ❑ Yes
- ❑ No / * Do you recommend initiation of CBT-I presently: _____

Is the patient interested in exploring assessment and treatment of other possible sleep disorders? [please circle if suspected or diagnosed]:

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

Other comments: _____

Referring Provider Name & Contact Info: _____

_____

If patient would like a progress report sent to referring physician/provider, please provide signed Consent for Release of Information.

Please fax to: 1-604-876-5889

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