

Patient Referral for Cognitive Behavioural Therapy for Insomnia

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

Address: _____

Phone #: _____ **Alternate phone #:** _____

* Consent to leave a confidential voice message? Yes No

Insomnia History (if known)

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