REFERRAL FORM (BEHAVIOURAL SLEEP MEDICINE)

Please provide a copy of this referral form and if applicable, a Mental Health Treatment Plan (MHTP), to the patient

Patients: Please upload this referral form and the MHTP (if applicable) when booking your appointment

Patient name _____ DOB _____

Address _____

Phone _____ Medicare card no. _____ Individual no. _____

Reason for referral *(Please mark all that apply)*

- ◯ Trouble falling asleep
- ◯ Trouble staying asleep
- ◯ Waking up too early
- ◯ CPAP adherence issues

Therapy preferred

- ◯ Cognitive behavioural therapy for insomnia (CBT-i)
- ◯ Sleep medication tapering alongside CBT-i
- ◯ Cognitive behavioural therapy for adjusting to CPAP therapy

Symptoms or medical conditions *(Please mark all that apply)*

- ◯ Pain or discomfort at night
- ◯ Anxiety and mood disorders
- ◯ Premenstrual dysphoric disorder (PMDD)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Pregnancy
- ◯ Lactation
- ◯ Perimenopause
- ◯ Post-menopause
- ◯ Other, please specify: _____

Any other relevant clinical information *(Please include prescribed sleep medications if any)*

GP name and practice _____ Provider no. _____

Email _____ Phone _____

Referring GP stamp or signature _____ Referral date _____

No. of sessions _____