



REFERRAL FORM

We accept referrals for adult and teen patients (13+) in Ontario and provide consultation and treatment for chronic insomnia and sleep timing concerns with the DECODE programs. Sleep investigations are not available. All services are delivered virtually and both audio/video are required. Patients are contacted by email with instructions to request a consultation. Patients must request an appointment and review clinic policies within 2 weeks of invitation. If no action is taken, the file will be closed and a new referral will be required.

PATIENT INFORMATION

Last Name		Given Name(s)	
Date of Birth	YYYY-MM-DD	Sex	
Email (Required)			
Phone			
OHIP and Version Code			
Reason for Referral	<input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Sleep timing concern <input type="checkbox"/> Sleep medication tapering <input type="checkbox"/> Interest in the DECODE treatment programs (CBT-I) <input type="checkbox"/> Other:		

REFERRING PHYSICIAN INFORMATION

Name			
Fax		Billing No.	
Other contact (optional)			
Signature		Referral Date	

I confirm this patient is being referred for insomnia or sleep timing concerns, resides in Ontario, can attend virtual visits, is interested in non-medication strategies for sleep, and understands adult CBT-I treatment includes a private-pay program component (sliding scale available).

Fax the completed form to 647-689-7588