Dr. **Judith R. Davidson**, Ph.D., C. Psych.
Adult Clinical and Health Psychology
Behavioural Sleep Medicine

128 Ontario St., Kingston, ON K7L 2Y4
Fax: 613-544-9793
Email: drdavidson@sinkintosleep.com

Referral Form

Client Contact Information

Name: _____
First *Last*

Address: _____
Number, Street *City/Town* *Province* *Postal Code*

Phone: _____

Can we leave voice messages? *(Preferred contact #)* ☐Yes ☐No *(Alternate contact #)* ☐Yes ☐No Email:_____ *(required)*

Date of Birth: _____ Gender: _____
MONTH Day,Year

Family Doctor: _____
Name *Address*

Emergency Contact Person

Name: _____
First *Last*

Phone: _____
(Preferred contact #) *(Alternate contact #)*

Relationship: _____

Sleep Concerns

- ☐ Insomnia
- ☐ Delayed Sleep Phase
- ☐ Other *(please specify)*: _____

Medical conditions (including other sleep disorders)

Other relevant information:

Medications:

Referral Information

Please check if self-referral ☐ *If external referral, please complete*

Referrer Name: _____ Phone: _____
First *Last*

Address: _____

Referral Date: _____
MONTH Day, Year