DIRECT REFERRAL

Postal Address: PO Box 561, Morningside QLD 4170
Dr C. Gray Ph: 3395 8633
Ms K. Smith Fax: 3395 8611

Patient Name...
Patient Address..

.... D.O.B..................

Patient Contact Number..

Clinical Details *(please tick)*

□ Adult (≥ 18 yr) with symptoms of persistent insomnia (≥ 4 wks) with associated morbidity.
□ Absence of significant unresolved Axis 1 psychiatric disorder, including substance abuse disorders.
□ No medical condition to account for complaint
□ Minimal hypnotic drug use.
□ Preparedness to abstain from, or limit, hypnotic drug use.
□ Poor sleep hygiene and/or poor sleep habits/rituals.
□ Capacity to tolerate 4 × 1 hr group treatment sessions.
□ Other..please specify...
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Referrer Details

Name..

Provider No...

Address...

....

....

Phone...

Signature...