Towards Better Sleep

Dr Curt Gray **M.B.B.S.,F.R.A.N.Z.C.P.** Ms Kathryn Smith **B.A,Grad.Dip.Psych.Ed.,M.Psych.,MAPS.,CCLIN.**

DIRECT REFERRAL

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Patient Name.....

Address.....

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

Telephone (h).....(m).....(w).....

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***.....

Date.....

□ Please contact me to discuss this referral.
Postal address: P O Box 3261, Newmarket 4051