PSYCHOLOGY CLINIC
at Queen's University

Queen's University
Department of Psychology
Queen's University
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Sleep Therapy Service, Psychology Clinic at Queen's University
Referral Form

The Sleep Therapy team includes doctoral Clinical Psychology students who are supervised by Dr. Judith Davidson, Ph.D., C. Psych.

Client Contact Information

Name: ____
First *Last*

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

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

Can we leave voice messages? ☐ Yes ☐ No ☐ Yes ☐ No

Email: ____________________

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
- ☐ Shift Work
- ☐ Delayed Sleep Phase
- ☐ Other *(please specify)*: ____________________

Other relevant information:

____

____

Medical conditions (including other sleep disorders)

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____

____

Medications____

____

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

Referrer Name: ____________________ Phone: ____________________
First *Last*

Address: ____

Referral Date: ____
MONTH Day, Year

For Office (Leave Blank) Date Received:____________________
QPC #:________________ Student:________________________