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Thank you for referring to the Rural and Remote Memory Clinic – Interventions (RRMCi). To better serve your patient, please complete the following, sign below, and fax to 306-966-1152.

CONTACT INFORMATION

Patient name: **Ph: h** **c**

Address:

Next of kin: **Ph: h** **c**

INTERVENTION PROGRAM TO WHICH YOU'RE REFERRING

☐ Cognitive Behavioural Training (CBTi) – for the treatment of insomnia/ chronic sleep disturbance

☐ Cognitive Rehabilitation – to help achieve personally meaningful goals

PERTINENT COMORBID CONDITIONS

☐ Sleep apnea
  ☐ Does ☐ Does not use CPAP

☐ Current substance abuse disorder

☐ Medically or psychologically unstable

☐ Seizure disorder

☐ Psychiatric disorder (e.g. bipolar disorder)

☐ Panic disorder

☐ Dementia or mild cognitive impairment

☐ Caregiving for person with dementia or cognitive impairment

MEDICATIONS FOR SLEEP DISTURBANCE

☐ Not applicable (Referring for Cognitive Rehabilitation)

☐ None

List current sleep medications: _____

REFERRING PHYSICIAN

Signature: _____ Date: _____

Did this form make this process easy ☐ or more difficult ☐ for you as a PHC provider?

This form is as updated September, 2021. Regularly check our website www.remotememoryclinic.ca to ensure you have most up-to-date version