SATA Centre for Conscious Living

MBTI Groups

https://www.satacentre.com/ https://mbtigroups.com/

Email: info@satacentre.com Fax: 1-236-800-7009

Group Mindfulness Behavioural Therapy for Insomnia (MBTI) Referral Form

8-week program. Weekly virtual group sessions.

****Inclusion criteria: Patients with Chronic Insomnia interested in group treatment using mindfulness and behavioural strategies**

Please fax this form to: 1-236-800-7009

Referring provider: _____ MSP: _____

Address: _____ Phone: _____

Signature: _____ Fax: _____

PATIENT INFORMATION

Name _____

Preferred Phone_____ Other Phone_____

PHN _____ Date of Birth _____

Address _____City _____ Postal Code_____

Gender (most identify with):_____ Pronouns_____

****Email**** _____

Does the patient meet the diagnostic criteria for chronic insomnia? (*Difficulty initiating or maintaining sleep or awakening too early in the morning. Sleep disturbances occur at least three times a week and have been present for the last 3 months. The sleep disturbance results in daytime dysfunction.*) □ **Yes** □ **No**

How has insomnia been treated so far? (e.g. medications, other) _____

_____

_____

Are there any other sleep issues apart from insomnia (e.g. sleep apnea, restless legs, circadian rhythm, sleepwalking/confusional arousal)? □ **Yes** □ **No**

If yes, please describe: _____

_____

_____

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**** Patients with untreated obstructive sleep apnea, restless legs syndrome, or other sleep disorders will not be accepted into the group until they have been treated.***

**** See page 3 of this form for quick screening tools for sleep apnea and restless legs syndrome.***

**** If you suspect OSA, RLS, or another sleep disorder, please refer the patient to a sleep clinic.***

Does the patient have any of the following exclusion criteria for this program: Active psychosis, mania, or hypomania; Seizure disorder; Current severe depression, or suicidal or homicidal ideation; Substance use significantly affecting function; Significant cognitive impairment? □ **Yes** □ **No**

Is the patient willing and able to avoid sedative/hypnotic use (or keep current use consistent) through the 8-week duration of the group? □ **Yes** □ **No**

Is the patient able to commit to 30 minutes of home meditation daily? □ **Yes** □ **No**

Are there any concerns about the patient's suitability for group participation (e.g. ability to self-regulate, mental or physical health instability). □ **Yes** □ **No**

MEDICAL CONDITIONS_____

_____

_____

MEDICATIONS _____

_____

_____

Allergies_____

Thank you for the referral! We will contact the patient for pre-group screening then tell you if they will be participating.

Laura McLean, MD, FRCPC

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Quick screening tools:

OBSTRUCTIVE SLEEP APNEA:

STOP-BANG Questionnaire http://www.stopbang.ca/osa/screening.php

STOP-Bang questionnaire

Please answer the following questions by checking "yes" or "no" for each one.

	Yes	No
Snoring (Do you snore loudly?)	❑	❑
Tiredness (Do you often feel tired, fatigued, or sleepy during the daytime?)	❑	❑
Observed Apnea (Has anyone observed that you stop breathing, or choke or gasp during your sleep?)	❑	❑
High Blood **P**ressure (Do you have or are you being treated for high blood pressure?)	❑	❑
BMI (Is your body mass index more than 35 kg per m^2?)	❑	❑
Age (Are you older than 50 years?)	❑	❑
Neck Circumference (Is your neck circumference greater than 40 cm [15.75 inches]?)	❑	❑
Gender (Are you male?)	❑	❑

Score 1 point for each positive response.

Scoring interpretation: 0 to 2 = low risk, 3 or 4 = intermediate risk, ≥5 = high risk.

Source: University Health Network, Toronto, Ontario, Canada (www.stopbang.ca/osa/screening/php). Used with permission from Sauk Prairie Healthcare.

- Patients who score 3 or higher need to be tested for obstructive sleep apnea.
- Note that a negative home sleep apnea test DOES NOT EXCLUDE obstructive sleep apnea. If OSA is suspected and HSAT is negative, the patient must be referred for polysomnography.

RESTLESS LEGS SYNDROME:

Your patient may have restless legs syndrome if they answer "yes" to the following question:

- ***When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement?***