

## Frequent/Chronic Migraine Referral

Referrals are being accepted for Botox injections in patients who meet the definition of Frequent/Chronic Migraine where oral therapies have failed or are not adequate in controlling headaches/migraine/pain.

First Name:		Last Name:		DOB (year/month/day)	
Address:			Phone:		Alternate Phone:
City:		Province:		Postal Code:	
Health Card Number:				M <input type="checkbox"/> F <input type="checkbox"/>	
Date of onset (if known):			Allergies:		
Family Physician:		Phone:		Fax:	
<b>Primary diagnosis given:</b>					
Past medical history:					
# Of Headaches/Month:			# Migraines/Month:		
<input type="checkbox"/> Neurological Consult completed			Date of Consult:		
<input type="checkbox"/> MRI/CT Scan completed			Date of Scan:		
Comments:					
<input type="checkbox"/> Medical report is appended		Has Botox been tried in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please check that patients being referred to the pain clinic meet these criteria:</b>					
<input type="checkbox"/> Secondary headache causes have been ruled out <input type="checkbox"/> Diagnosed with Chronic Migraine (> 15 headache days/month with >8 being Migraine) <input type="checkbox"/> Established patient has failed or is not suitable with 1-2 other prophylactic interventions (please list in below section) <input type="checkbox"/> Patient is amenable to this alternative therapy to headache treatment <input type="checkbox"/> Patient has insurance coverage for prophylactic treatment <input type="checkbox"/> Patient qualifies for exceptional access coverage under ODB					
Previous Therapies: (Please select all therapies tried and list drug name)					
<input type="checkbox"/> TCAs Name:		<input type="checkbox"/> Beta Blockers Name:		<input type="checkbox"/> Non Opioid Analgesics Name:	
<input type="checkbox"/> Triptans /#Qty/Month:_____		<input type="checkbox"/> Anticonvulsants Name:		<input type="checkbox"/> CCBs Name:	
<input type="checkbox"/> Opioid Name:		<input type="checkbox"/> Prednisone Name:		<input type="checkbox"/> Ergots Name:	
<input type="checkbox"/> Other (please specify)					
General Comments:					
Referring Physician's Name: (please print)			Physician's Signature:		
Billing Number:			Date:		