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/migraines/pain.

First Name:	Last Name:	DOB (year/month/day):
Address:	Phone:	Alternate Phone:
City:	Province:	Postal Code:
Health Card Number:		M ☐ F ☐
Date of Onset (if known):	Allergies:	
Family Physician:	Phone:	Fax:
Primary Diagnosis Given:		
Past Medical History:		
# Of Headaches/ Month:	# Migraines/Month:	
☐ Neurological Consult completed	Date of Consult:	
☐ MRI/CT Scan completed	Date of Scan:	
Comments:		
☐ Medical report is appended	Has Botox been tried in the past? ☐ Yes ☐ No	

Please check that patients being referred to the pain clinic meet the following criteria:

☐ Secondary headache causes have been ruled out
☐ Diagnosed with Chronic Migraine (> 15 headache days/month with > 8 being Migraine)
☐ Established patient has failed or is not suitable with 1-2 other prophylactic interventions (please see list below)
☐ Patient is amendable to this alternative therapy to headache treatment
☐ Patient has insurance coverage for prophylactic treatment
☐ Patient qualifies for exceptional access coverage under ODB

Previous therapies: (Please select ALL therapies tried and list drug name)

☐ TCA Name:	☐ Beta Blockers Name:	☐ Non Opioid Analgesics Name:
☐ Triptans / #Qty/ Month:______ Name:	☐ Anticonvulsants Name:	☐ CCB's Name:
☐ Opioid Name:	☐ Prednisone Name:	☐ Ergots Name:
☐ Other (Please specify):		
General Comments:		
Referring Physician's Name: (Please print)	Physician's Signature:	
Billing Number:	Date:	