ALBERTA
NEUROLOGIC CENTRE
Excellence in Neurologic Care for Albertans

ALBERTA NEUROLOGIC CENTRE
Suite 300, 1608 17th Avenue SW, Calgary, Alberta, T2T 0E3
Phone: 587-747-5615 Fax: 587-747-5616
Website: www.ancentre.ca

EXPEDITED MIGRAINE REFERRAL FORM (1-3 WEEKS)

Dr. Sameer Chhibber
MD, FRCPC (Neurology), CSCN (EMG)

Dr. Scott Jarvis
MD, PhD, FRCPC (Neurology)

Dr. Evgenia Klourfeld
MD, MSc FRCPC (Neurology)

Dr. Lisa Rosenegger
MD, PhD, FRCPC (Neurology)

AND ASSOCIATES

Referrals will be triaged and scheduled with the first available provider

Name: _____ Date of Birth_____ ULI: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

REFERRAL INFORMATION

Has the patient been treated in the past with Botox for headaches?

☐ **Yes** ☐ **No**

Medications currently being used:

_____

_____

Referring Physician

NAME: _____

PRAC ID:_____

Phone: _____

Fax: _____

Physician to Receive Copies

_____

_____

WCB Number_____

CLINICAL QUESTIONS

Diagnosis of Migraine

2 of the following (please check):

- ☐ Throbbing
- ☐ Moderate-severe intensity
- ☐ Unilateral location of pain (can be bilateral)
- ☐ Pain aggravated by activity/ activity is avoided or worsens pain

1 of the following (please check):

- ☐ Nausea and/or vomiting
- ☐ Photophobia and phonophobia

Days of Headache

Both of the following (please check):

- ☐ ≥15 headache days/month (8 of which are migrainous)
- ☐ For at least 3 months

Ask your patient "on how many days a month are you headache free?" _____

Would your patient benefit from nerve blocks and/or IV migraine infusion therapy? _____ (these services are available at Alberta Neurologic Centre)

Relevant History and Examination: (include any relevant investigations, imaging studies, consults)

Referring Physician Signature:_____ **Date:** _____

*Please fax completed referral to ANC at **587-747-5616***