



EXPEDITED MIGRAINE REFERRAL FORM

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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

<p>Has the patient been treated in the past with Botox for headaches?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medications currently being used:</p> <p>_____</p> <p>_____</p>	<p>Referring Physician</p> <p>NAME: _____</p> <p>PRAC ID: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Physician to Receive Copies</p> <p>_____</p> <p>_____</p> <p>WCB Number _____</p>
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CLINICAL QUESTIONS

Diagnosis of Migraine
 2 of the following (please check):

<input type="checkbox"/> Throbbing	1 of the following (please check):
<input type="checkbox"/> Moderate-severe intensity	<input type="checkbox"/> Nausea and/or vomiting
<input type="checkbox"/> Unilateral location of pain (can be bilateral)	<input type="checkbox"/> Photophobia and phonophobia
<input type="checkbox"/> Pain aggravated by activity/ activity is avoided or worsens pain	

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