WEST END HEADACHE MD

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PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name in use: _____

Legal name: _____ Date of Birth: ___/___/_____
DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Eligibility Criteria:
Age: 18 and over
Diagnosis: Migraine, Cluster Headache, Trigeminal Autonomic Cephalalgias, other headaches

Exclusion Criteria:
- Patient is already being seen by another headache specialist.
- Patient is on daily opioid medication(s).

Referral Date: ___/___/_____
DD/MM/YYYY

Language spoken: _____

Allergies: _____

Preferred Name: _____

Gender: _____

Pronouns: ❑ She, Her ❑ He, Him ❑ They, Them ❑ Other: _____

SCOPE PCP INFORMATION:

Name:	Address:
Telephone:	Fax:
Billing Number:	Signature:

REASON FOR REFERRAL:

1. Presumed Headache Diagnosis/Chief Complaint:

2. Is the headache problem:
❑ New (Less than 3 months) ❑ Chronic Daily
❑ Worsening of Previous Pattern ❑ Difficult to Treat

3. Is there relevant neuroimaging?
❑ Yes
❑ No

4. Are you concerned these are secondary headaches?
❑ Yes
❑ No

5. Is this patient:
❑ Pregnant
❑ Pregnancy Planning
❑ N/A

6. Have they seen a headache specialist or neurologist within the last 2 years?
❑ Yes
❑ No

HEADACHE THERAPIES TRIALED (√):

PREVENTIVE	Previous	Current	ACUTE	Previous	Current
Nadolol/Propranolol			1.		
Candesartan			2.		
Amitriptyline			3.		
Topiramate					
Gabapentin					
Botox					
Other: _____					

Days per month of acute treatments? _____

Is the patient currently using opioids? ❑ Yes ❑ No

ADDITIONAL COMMENTS:

Please attach the following:
► Past and current medical history
► Current Medications
► Neuroimaging
► Consults