Headache Referral Form
Advice & Guidance and Referral Form

NHS Sussex

Please complete this form where possible and appropriate.

REASON FOR REFERRAL (please tick)	
☐ Diagnostic uncertainty ☐ Difficult to manage migraine ☐ Managing a non-migraine headache – please specify working diagnosis	
RED FLAGS - if any of the following red flags are present, please referral on an Urgent Suspected Cancer (USC) pathway using the appropriate NG12 form.	
• Chronic infection: HIV, TB • Immunosuppression • Past medical history of cancer • Weight loss • Older (age >50 years) new onset, persistent/progressive headache • Prior history new onset or change to persistent/daily headache.	• Positional orthostatic, recumbent, worsens with change in position, or wakes patient from sleep with pain • Pregnancy/ postpartum new onset during pregnancy • Precipitated by Valsalva, cough, sneeze, bending, straining
If no red flags, are ANY of the following features present? (please tick):	
1. Duration > 4 hours (episodic headache)	☐ Yes
2. Two of the following:	☐ Unilateral ☐ Moderate or severe pain intensity ☐ Pulsating quality ☐ Aggravated by everyday activities (e.g., walking or climbing stairs)
3. At least one of the following:	☐ Nausea and/or vomiting ☐ Photophobia and phonophobia
If yes to all three of the above questions, and no red flags are present, the diagnosis is likely to be migraine. Please list prior preventatives used including maximum dose tolerated and treatment duration.	
PROPHALAXIS TREATMENT	
Prior to referral patients should have tried at least two prophylaxis treatments at maximum dose (see local formularies). **Please provide information on name and duration:**	

Analgesia overuse present? Yes ☐ No ☐ Uncertain ☐

(Acute analgesics should be used fewer than 10 days per month or two days a week, to avoid development of 'medication overuse headache'. Prophylactics may fail unless analgesic use is reduced).

If yes, please provide information on name and duration:

IMPORTANT INFORMATION AND RESOURCES

Headache Diary: Please ensure the patient keeps a headache diary and brings this to their appointment. Example at https://migrainetrust.org/live-with-migraine/self-management/keeping-a-migraine-diary/

Patient Information: Please sign-post the patient to www.migrainetrust.org for information

ACTIONS PRIOR TO REFERRAL

Ensuring that the following information accompanies the referral will enable effective clinical decision making and ensure patients are seen in the right clinic, first time.

- Last recorded: ESR, CRP, BP, Smoking, Alcohol
- Previous imaging and/or investigations (last recorded or in the last 12 months)
- Problem list (significant active and significant past)
- Previous treatment (reason for discontinuation i.e ineffective or not tolerated due to side effects)

PATIENT DETAILS

Name	<Patient Name>	[GENDER]	
NHS Number	<NHS number>	[ETHNICITY]	
DOB	<Date of Birth>	Interpreter Required	☐ Yes
Patient's Address	<Patient Address>	<Main spoken language>	
Home phone	<Patient Contact Details>	Need for advocate/ carer present?	☐ Yes
Mobile phone	Patient Contact Details>	Assistance with booking required	☐ Yes
Work phone	<Patient Contact Details>	Wheelchair user	☐ Yes
Email	<Patient Contact Details>	Transport required	☐ Yes

Frailty: Please enter the WHO Performance Score:

☐ 0 Fully active, able to carry on all pre-disease performance without restriction.
☐ 1 Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.
☐ 2 Ambulatory and capable of all self-care but unable to carry out any work activities.
☐ 3 The patient is up and about more than 50% of waking hours.
☐ 4 Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.
☐ 5 Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair

Request for: ☐ **Advice and Guidance** ☐ **Routine Referral** ☐ **Urgent Referral**

Is the patient suitable to be booked for direct diagnostics/ investigations?	☐ Yes	☐ No
Is the patient suitable for a telephone/video appointment?	☐ Yes	☐ No

CLINICAL DETAILS

History (* required information)

- Smoking status* [CODE]
- Alcohol consumption * [CODE]
- ESR * [CODE]

- CRP * [CODE]

Examination

- Height * [CODE]
- Weight * [CODE]
- BMI: [CODE]
- Blood pressure * [CODE]

ADDITIONAL INFORMATION/QUESTIONS

Please add any free text here e.g., any supporting information, any specific questions you would like addressed etc.

☐ Reports on any relevant imaging investigations in last 12 months are attached

REFERRER INFORMATION

Referred by		Role		Date	
Phone		Email			
GP	[GP] [GP Practice] [Practice Address]				