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 Botox Chronic Migraine Referral Form

Directed to:

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Dr. Scott Jarvis	MD, PhD, FRCPC-Neurology	**PRAC-ID** 4290-57208
Dr. Lisa Hoyte	MD, DPHIL, FRCPC-Neurology	**PRAC-ID** 9188-10308
Dr. Jonathan Fridhandler	MD, FRCPC-Neurology, CSCN (EMG)	**PRAC-ID** 9809-20308
Dr. Theodore Mobach	MD, FRCPC-Neurology	**PRAC-ID** 7219-60308
Dr. Daniel Fok	MD, FRCPC-Neurology	**PRAC-ID** 2209-20308

Please fax completed form to **587-747-5616**

Patient name: _____

Birth date (DD MM YYYY): _____

Health card #: _____

Address: _____

Phone number (daytime): _____

Please complete the Chronic Migraine Checklist and attach relevant medical notes, including and any relevant medical imaging.

Chronic Migraine Checklist

Has the patient been treated in the past with Botox for headaches? **YES –** when? _____ **NO**

Please list medications currently being used for headaches: _____

_____

Diagnosis of Migraine

2 of the following (please check):

- ☐ Throbbing
- ☐ Moderate–Severe intensity
- ☐ Unilateral location of pain (can be bilateral)
- ☐ Pain aggravated by activity or ADLs

1 of the following (please check):

- ☐ Nausea and/or Vomiting
- ☐ Photophobia and Phonophobia

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Days of Headache - Ask your patient "on how many days a month are you headache free?"

Both of the following (please check):

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

Referring physician (please print): _____

Clinic Phone: _____

Clinic Fax: _____

Referring physician signature: _____

Referring physician PRAC-ID: _____