WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street, Toronto, Ontario M5S 1B2
Telephone: 416-323-6136 Fax: 416-323-6007

CENTRE FOR HEADACHE REFERRAL FORM

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

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ____/____/_____
DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

ADDITIONAL PATIENT INFORMATION

Preferred name: _____

Gender : _____ Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

Interpreter required: ☐ Yes ☐ No Language spoken: _____

Healthcare card number/Health insurance: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____

Telephone: _____ Fax: _____

Address: _____ Signature: _____

Alternate report sent to (name/contact information): _____

FAMILY DOCTOR INFORMATION

Name: _____ Address: _____

If your patient is required to attend our education and chooses not to, the referral will be cancelled.
If no standard headache therapies have been tried, the referral will likely be rejected. Please see Canadian Headache Society guidelines.

What is the Clinical Question? _____

Headache Diagnosis/ Headache History (include frequency number/day/week/month): _____

_____

_____

Previous neuroimaging: ☐ Yes (attach report) ☐ No

Prior headache/pain specialist seen: _____

Current medications (List all prescription and non-prescription): _____

Medication	Dose	Date started
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

OPIOID USE: ☐ Yes If yes, quantity prescribed per month? _____ ☐ No

Previous headache medications tried and outcomes: _____

Medication	Date tried	Outcome
	DD / MM / YYYY	
	DD / MM / YYYY	
	DD / MM / YYYY	

Medical/psychiatric/social history: _____

_____

_____