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

CENTRE FOR HEADACHE REFERRAL FORM

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____

Name:_____

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

Address:_____

Telephone:_____ Alternate #:_____

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.

ADDITIONAL PATIENT INFORMATION

Preferred name: WCH Medical Record Number (*if known*):

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

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____
Primary Care Provider Telephone: _____

REASON FOR REFERRAL

What is the clinical question?_____

Headache diagnosis / headache history (include frequency number/day/week/month):_____

_____

_____

Previous neuroimaging: ☐ No ☐ Yes (attach report)

Prior headache/pain specialist seen: ☐ No ☐ Yes (attach relevant consult notes)

OPIOID USE: ☐ No ☐ Yes - quantity prescribed per month?_____

CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION)	Dose	Date started
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

PREVIOUS HEADACHE MEDICATIONS	Date tried	Outcome
	DD / MM / YYYY	
	DD / MM / YYYY	
	DD / MM / YYYY	

Medical / psychiatric / social history: _____

_____

_____