Cleveland Clinic
Canada

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Headache Program Referral Form

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

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

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

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

ADDITIONAL PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Gender:	Name:
Allergies:	Address:
	Telephone: Fax:
	Alternate report sent to: (name/contact information)
	Billing number: _____
	Signature: _____

Headache working 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: _____

_____

_____

Send completed form to: **headacheprogram@ccf.org**
If you have any questions, please call: **416-507-6789**