WCHI
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

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: Allergies: Insurance coverage/self-pay: Language spoken: Interpreter required: ❑ Yes ❑ No	Name: Address: Telephone: Fax: Alternate report sent to: (name/contact information) Billing number: _____ Signature:_____

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.

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: _____

_____

_____