U of T NEUROLOGY

Sunnybrook HEALTH SCIENCES CENTRE

A-455 - 2075 Bayview Ave.
Toronto, ON M4N 3M5
Phone: 416-480-6100 x1961
Fax: 416-480-4990

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name in use: _____

Legal name: _____ Date of Birth: ___/___/___
DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Sunnybrook Headache Clinic

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

Language spoken: _____

Allergies: _____

Preferred Name: _____

Gender: _____

Pronouns: ❑ She, Her ❑ He, Him ❑ They, Them ❑ Other: _____

PCP INFORMATION:

Name:	Address:
Telephone:	Fax:
Billing Number:	Signature:

REASON FOR REFERRAL:

1. Presumed Headache Diagnosis/Chief Complaint:

2. Is the headache problem:
- ❑ New (Less than 3 months)
- ❑ Worsening of Previous Pattern
- ❑ Chronic Daily
- ❑ Difficult to Treat

3. Is there relevant neuroimaging?
- ❑ Yes
- ❑ No

4. Are you concerned these are secondary headaches?
- ❑ Yes
- ❑ No

5. Is this patient:
- ❑ Pregnant
- ❑ Pregnancy Planning
- ❑ N/A

6. Have they seen a headache specialist or pain clinic within the last 2 years?
- ❑ Yes
- ❑ No

HEADACHE THERAPIES TRIALED (√):

PREVENTIVE	Previous	Current
Nadolol/Propranolol		
Candesartan		
Amitriptyline		
Topiramate		
Gabapentin		
Botox		
Other: _____		

ACUTE	Previous	Current
1.		
2.		
3.		

Days per month of acute treatments? _____

Is the patient currently using opioids? ❑ Yes ❑ No

ADDITIONAL COMMENTS:

Please attach the following:
- ► Past and current medical history
- ► Current Medications
- ► Neuroimaging
- ► Consults