

800 John Marks Avenue, Kingston, ON, K7K 0J7

**BOTOX for Migraine Consultation Request**  
**Please fax completed forms (2 pages) to 613-344-1203**

Patient name: \_\_\_\_\_  
Birth date (DD MM YYYY): \_\_\_\_\_  
Health card #: \_\_\_\_\_ Version \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number (daytime): \_\_\_\_\_

**Patients being referred should meet these criteria:**

- Secondary headache causes have been ruled out.
- Diagnosed with Chronic Migraine (> 15 headache days/month with >8 being features of migraine)
- Established that patient has failed or is not suitable with 1-2 oral prophylactic interventions.
- Patient is amenable to injections.
- Patient has insurance coverage for prophylactic treatment **OR**
- Patient would qualify for Exceptional Access Program (Ontario Drug Benefits).  
(A 3 month headache diary required and failure of 3 oral prophylactics from 2 different classes)

Referring physician (please print): \_\_\_\_\_  
Physician OHIP #: \_\_\_\_\_  
Clinic phone #: \_\_\_\_\_  
Referring physician signature: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date received: \_\_\_\_\_ Appointment date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Is this patient new to BOTOX® therapy for Chronic Migraine?  Yes  No

Length of Time Patient afflicted with Chronic Migraine (i.e., # months or years): \_\_\_\_\_

Number of Headache/Migraine Days per month: \_\_\_\_\_ Duration of Headaches/Migraines: \_\_\_\_\_  Hours  Days

**Relevant Diagnostic or Confirmatory Tests Performed**

Neurological Consult Date: \_\_\_\_\_ Comments: \_\_\_\_\_

MRI/CT Scan Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Other (Specify Date and Type): \_\_\_\_\_

**All Prior Relevant Treatments**

Non-Opioid Analgesics  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Tricyclic antidepressants  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Prednisone  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Ergots  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Anticonvulsants  
 Topiramate  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Beta Blockers  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Calcium Channel Blockers  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Opioids  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Triptans  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

\_\_\_\_\_  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

\_\_\_\_\_  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

\_\_\_\_\_  
Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Duration: \_\_\_\_\_  Effective  Ltd Benefit  Ineffective  Not Tolerated

Physician Signature \_\_\_\_\_