Silverado Medical Clinic

Botox for Chronic Migraine Diagnostic Form

Referring Physician Information			
Name:	Folake Pepple	**PRAC ID#:**	838454208
Address:	#802 19369 Sheriff King St. SW Calgary, AB T2X 0T9	**Phone:**	(403) 873 8999
		Fax:	(403) 873 8880
Indication for Referral:			

Has this patient undergone Cranial Imaging? Yes ☐ No ☐ If yes please attach reports

Physician Signature:	

Section to be Completed by Patient:

Name: _____ D.O.B: _____

Address: _____ Daytime Phone: _____

Health Card #:_____ (or attach label with patient information)

Do you have an active claim with WCB for this headache condition? Yes ☐ No ☐

Do you have an active insurance or legal claim for this headache condition? Yes ☐ No ☐

How many days in the past month were you headache-free? _____ (days)	How many days in the past month did you have migraine (include any days you took a Triptan/Ergot and had relief) ? _____ (days)

When you have Migraine, what symptoms do you have? (check all that apply)

One side of your head ☐ Both sides of your head ☐ Pulsating/Throbbing ☐ Light sensitivity ☐

Moderate to Severe pain ☐ Aggravated by/causing you to avoid physical activity ☐ Nausea and /or Vomiting ☐

Do you have difficulty swallowing? Yes ☐ No ☐ Have you been diagnosed with Myasthenia Gravis? Yes ☐ No ☐

Have you had Botox in the past for headaches? Yes ☐ No ☐ or other Botox treatment in the past three months? Yes ☐ No ☐

If "Yes" when was your last treatment (DD/MM/YYYY)? _____ are you willing to undergo Botox injections? Yes ☐ No ☐

What medications are you currently taking?

What medications have you taken in the past for your migraines?

Did your headaches respond to any Triptan or Ergot medications? Yes ☐ No ☐