



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: _____ Email: _____

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

ADDITIONAL PATIENT INFORMATION

Gender: _____
Allergies: _____

REFERRING PROVIDER INFORMATION

Name: _____
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: _____