ÉQUIPE DE SANTÉ FAMILIALE
www.bywardfht.ca
Tel/Tél: 613-564-3950

ByWard
300-100 Marie Curie PVT
Ottawa, Ontario K1N 6N5

FAMILY HEALTH TEAM
www.bywardfht.ca
Fax/Téléc: 613-564-6627

Botox for Chronic Migraines Referral Form

Please fax completed referral form to **1-613-564-6627**

Referring MD/NP Information:
MD/NP Stamp & Billing #

Patient Contact Information:
For Patient Label

Requirements for a patient to be considered an appropriate candidate for BOTOX injections:

- ☐ **Secondary causes of headache have been ruled out (SNOOP)**
- ☐ **Diagnosed with Chronic Migraine**
  (>15 headaches day/month with > 8 days being features of migraine)
- ☐ **Patient is amiable to this alternative therapy to headache treatment**
- ☐ **Patient has failed or is not suitable with 1-2 other prophylactic interventions (please list name of medication with start/stop dates in referral)**
- ☐ **Confirmation of private health coverage and willingness to cover cost of $150.00 for BOTOX treatment/procedure, if applicable**

Physician/Nurse Practitioner Signature:

Billing #: Date: