ÉQUIPE DE SANTÉ FAMILIALE
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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**
- ☐ **Diagnosed with Chronic Migraine**
  (>15 headaches day/month with migraine features)
- ☐ **Patient is amiable to this alternative therapy to headache treatment**
- ☐ **Patient has failed 2 prophylactic medications (not effective or intolerable side effects). If patient is on Ontario Drug Benefit (ODB), failure of 3 prophylactic medications are required (please list name of medication with start/stop dates in referral)**

Medical History

Diagnosis: Chronic migraine Episodic migraine Number of migraine days per month (at least 4): Number of headache days per month:

List all previous preventive medication used prior to QULIPTA in the table below. HIT-6 score (if applicable):

Preventive medication (please indicate at least 2 different classes of medication; for patients on ODB, please list 3) Include name and dosage.	Lack of efficacy/Inadequate response	Side effects/ Intolerance	Contraindicated	Date started (mm/yyyy)	Date finished (mm/yyyy)

Confirmation of private health coverage or ODB and willingness to cover cost of $150.00 for BOTOX injection procedure. A receipt would be given for Health Spending Account (HSA) with private insurance company.

***Medication is covered by your private insurance company or ODB. There are support options available through the pharmacy to maximize your coverage.**

I am part of a Family Health Team organization (Yes/No)

***If Yes (part of a Family Health Team), the initial visit is billed as a consult. All subsequent visits will not be billed with in basket (A007) code.**

Physician/Nurse Practitioner Signature:

Billing #: **Date:**