OUTPATIENT REFERRAL FORM

Botox Service for Chronic Migraine

This form can be submitted by email or fax:
Fax: 01244 665331
Email: info@stgeorgehealthcaregroup.co.uk

Countess of Chester Health Park
Liverpool Road
CH2 1HJ
Tel: 01244 665330
www.stgeorgehealthcaregroup.co.uk

Referral subject to contra-indication screening protocol.
Supply additional information on separate sheet as needed.

Referral Details:

Patient's name			Date of Birth	
Address	Permanent Address		Current Address (if different)	
	Telephone		Telephone	
	Mobile		Email	

Referrer name			Designation	
Address	Address		Address	
	Telephone		Telephone	
	Fax		Fax	

Clinical History

Inclusion criteria for chronic migraine clinic (please mark relevant boxes to confirm)

- ☐ Confirmed diagnosis of chronic migraine
- ☐ Possibility of secondary headache excluded
- ☐ Headaches on 15 or more days per month for at least 3 months, with headaches being migrainous on at least 8 days per month
- ☐ Unsatisfactory response to, or unable to tolerate standard acute and prophylactic migraine treatment (or unable to take due to contra-indications)

Exclusion criteria for chronic migraine clinic (please mark relevant boxes to confirm that the patient has no contra-indications to treatment with Botox®)

- ☐ No known hypersensitivity to any constituent of Botox®
- ☐ Not pregnant or breastfeeding
- ☐ No current infection at proposed injection sites (shoulders, neck and head)

The patient must meet all the above criteria to be eligible for referral to the clinic

History of presenting Condition (including date of onset and current status):
Reason for referral/ Therapeutic Goals:

Past Medical History:	
Social History (NOK, Accommodation, hobbies, occupation as relevant):	
Patient Name:	Date of Birth:
Referrer Name:	Designation:

PAYMENT DETAILS

Name	Self Funded – Payment at point of treatment		
Address			
Telephone		Fax	Mobile

ANY OTHER RELEVANT INFORMATION