Children's Hospital
London Health Sciences Centre

Paediatric Neurology Headache Clinic Referral Form (LHSC ER specific)

Indications for Referral

- **If diagnosis is in doubt.**
- **If focal neurological symptoms or signs.**
- **If patient has failed at least two trials of appropriate therapies**
  (e.g. Robust doses of Ibuprofen and Tylenol as symptomatic treatment)
  (e.g. Amitriptyline, Nortriptyline , Flunarizine, Propranolol for at least three months)

Patient Name:_____ ***DOB:***_____ ***PIN #:*** _____

Address: _____ ***Phone:***_____

Health Card #: _____

This referral is: ◯ Urgent ◯ Non urgent

Are you concerned these are secondary headaches ◯ YES ◯ NO

Have you spoken with Paediatric Neurology? ◯ YES ◯ NO
If Yes, when and with whom? _____

From your perspective are these headaches:

◯ Acute ◯ Acute recurrent ◯ Chronic Progressive ◯ Chronic non progressive[1]

Headache ◯ <3 months ◯ >3 months

Neurological Exam: ◯ Normal ◯ Abnormal

Abnormal Findings: _____

Fundoscopy exam ◯ Normal ◯ Abnormal

Abnormal Findings: _____

Number of ER visits in past year for headaches? _____

Diagnostic Imaging ◯ Yes ◯ No

Date/Results: _____

Prophylactic meds:_____

Psycho/emotional co-morbidites ◯Depression ◯ Anxiety ◯ Other _____

Are the parents worried about these headaches? ◯ Yes ◯ No

Frequent analgesia intake (> 2-3x/week) : ◯ Yes[2] ◯ No

How many days per week: _____

1 *If Chronic Non Progressive with normal neuro exam and H/A > 3 months, please give patient with our* ***standard*** *Headache Clinic Referral form and request* ***their health care provider to make the referral to our program****.*

2 *If there has been frequent analgesia intake and you believe these are primary headaches, please recommend* ***a mediation holiday*** *for* ***one month*** *and request the patient follow-up with health care provider after this time for a referral to the Headache Clinic if still needed.*