REGIONAL PAEDIATRIC TERTIARY HEADACHE CLINIC REFERRAL FORM

In order to help us better meet the needs of the children referred to our Regional Paediatric Tertiary Care Headache clinic, we require the following THREE pages of information to be completed before a referral can be reviewed. We thank you in advance.

Please FAX completed form to 519 685-8350

DATE OF REQUEST FOR CONSULTATION	
REQUESTING PRACTITIONER	
OFFICE ADDRESS	
OFFICE TELEPHONE NUMBER	
OFFICE FAX NUMBER	

PATIENT NAME	
HEALTH CARD NUMBER	
PATIENT DATE OF BIRTH	
PATIENT ADDRESS	
PATIENT PHONE NUMBER:	
ALTERNATE NUMBER:	
Will an interpreter be required?	**Language:**

REASON FOR REQUEST/SPECIFIC QUESTION(S) TO BE ANSWERED:

1. _____

2. _____

Regional Paediatric Tertiary Headache Clinic, Children's Hospital, London Health Sciences Centre
Room B1-169A, North Tower, Victoria Hospital, 800 Commissioner's Rd E, London, ON, N6A 5W9
Phone: 519 685-8332 Ext 2 Fax: 519 685-8350

Do you think this referral is: Urgent Semi-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? _____

How long has the child had headaches? _____

How often is the child seen in your office for headache management? _____

What date was the child last seen by you? _____

In the past three months have the headaches become worse? ◯ YES ◯ NO

If yes, how so: ◯ Frequency ◯ Severity ◯ Duration

Has the child kept a headache diary? ◯ YES For how long? _____ ◯ NO

Does the child have more than 15 headaches per month? ◯ Yes ◯ No

From your perspective are these headaches:

◯ Acute ◯ Acute recurrent ◯ Chronic Progressive ◯ Chronic non progressive

Note: *Please see suggestions below for Chronic Non Progressive headaches, if they have not been tried.*

- *Symptomatic Treatment with Robust doses of Ibuprofen (10mg/kg. Max 600 mg/dose) or Acetaminophen (20 mg/kg Max 1 Gm/dose)* ***Not to be used >8 days/month***
- *Prophylactic Treatment for headache occurring >10 days/month with either Amitriptyline, Nortriptyline, Flunarizine, Propranolol, Topiramate, or Valproic Acid for at least three months. We suggest a 3 month trial of at least two separate medications without success before making a referral to our program.*

Neurological Exam: ◯ Normal ◯ Abnormal

Abnormal Findings: _____

Fundoscopy exam ◯ Normal ◯ Abnormal

Abnormal Findings: _____

Diagnostic Imaging ◯ Yes ◯ No

Date/Results: _____ Reports Attached ◯ Yes ◯ No

If NO, state why not _____

Are there psycho/emotional co-morbidities? ◯Depression ◯ Anxiety ◯ Other _____

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

What type of reassurance has been provided? _____

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Is there frequent analgesia intake (> 3x/week for > 3 months)? ◯ Yes* ◯ No

If NO, how many days per week? _____

***NOTE:** If there has been frequent analgesia intake and you suspect medication overuse headache please recommend* a **medication holiday from ALL analgesia for one month** *and please reassess the patient in follow-up to confirm whether a referral to the Headache Clinic is still needed.*

Was a 4 week medication holiday completed? ◯ Yes ◯ No

What were the results? _____

In the last 6 months has the child received headache treatment in an emergency department? ◯ Yes ◯ No

When? _____

How many days in the past three months has the child missed school_____, work _____

or social activities _____ due solely to headaches?

What medications has the child tried in the past for headache management?

Please list total dose achieved and duration for each. Attach a separate sheet if needed.

1.
2.
3.
4.

What medication(s) is the child currently taking for headaches? Please list total dose achieved and duration for each. Attach a separate sheet if needed.

1.
2.
3.
4.

Please assure all accompanying information, such as imaging studies, investigations, and other consult summaries, are sent to our office along with this referral.

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