Headache, Migraine & Concussion Centre

Non-Narcotic Medical Pain Management

Please complete and Fax this form to 1 (866) 380-2423

Patient Info

Health Card No_____VC_____Date of Birth _____

Full Name_____Main Tel./Mobile_____Alt.Tel._____

Address_____City_____Postal Code_____

Province_____Does this patient have 3rd party coverage? If yes, please provide insurance provider: _____

This patient is a: ☐ New Patient ☐ Re-referral History of drug/alcohol abuse or addiction? ☐ Yes ☐ No

Physician Info

CPSO #_____Billing #_____

Dr./NP_____Tel_____Fax_____

Address_____City_____Postal Code_____

Province_____ Are you the patient's Family Physician or Most Responsible Physician (MRP)? ☐Yes ☐No

Do you belong to a: ☐FHO ☐FHT ☐FHG ☐CCM ☐Other_____

Reasons for Referral

Medical Problem/Diagnosis: ☐ Headaches ☐ Migraines ☐ Neck Pain

Onset (since when):_____Duration:_____

Location:_____Imaging Results:_____

Medications Tried:_____

Previous Consults (Neurology, Pain Clinic):_____Other:_____

Current Medication/Supplements:_____

Patient has tried at least 2 prophylactic migraine medications found to be Ineffective/intolerant

1. Medication_____ Start Date _____ Stop Date _____
2. Medication_____ Start Date _____ Stop Date _____
3. Medication_____ Start Date _____ Stop Date _____
4. Medication_____ Start Date _____ Stop Date _____

To expedite the referral, please provide:

- Patient's Medical History
- Diagnostic and/or consultation reports
- Current Medications

As the most responsible physician, by signing below, I agree to continue the patient'sprescription and primary care once the patient is stable and under the care of HMCC.

_____ Physician Signature

_____ Date

Address: 555 Kingston Road West, 1st Floor, Ajax, ON. L1S 6M1 | Phone: 905-477-4677 | Fax: 866-380-2423