London Health Sciences Centre

Dr. John H. Kreeft Headache Clinic - Referral Form

Department of Clinical Neurological Sciences Facsimile: 519 - 663-2933
Victoria Hospital – East Tower – 800 Commissioner's Rd. E. London, ON For appointments call: 519 - 663-2906
Paul E. Cooper, MD, FRCPC - Clinic Director

This form will help us to accurately triage the patients you refer to the clinic. We hope this will ensure that the patients who need to be seen soonest, are seen in a timely fashion. Please make copies of this form for subsequent referrals. All appointments are made through Dr. Cooper's office at University Hospital but patients are seen in the Headache Clinic at Victoria Hospital.

PLEASE NOTE: ALL PATIENT DEMOGRAPHICS MUST BE CLEARLY PROVIDED (LEGIBLE) & NAME OF REFERRING DOCTOR OR AN APPOINTMENT CANNOT BE MADE.

A. PATIENT NAME: _____
DATE OF REFERRAL: _____

PLEASE PROVIDE or ATTACH: current mailing address (including postal code), home phone number, work number (if applicable), date of birth, and health card number

Referring Physician Name; Address, Phone and FAX number OHIP referral number

B. **PRESENT WORKING DIAGNOSIS** (check as many as apply)

- ☐ tension-type headache
- ☐ chronic daily headache
- ☐ migraine
  - ☐ with aura
  - ☐ without aura
- ☐ medication-induced headache
- ☐ post-traumatic headache
- ☐ mixed migraine-tension-type
  - ☐ unable to classify
- ☐ cluster headache
- ☐ other_____

C. **I AM CONCERNED ABOUT** (check as many as apply)

- ☐ the unremitting nature of these headaches
- ☐ the lack of response of these headaches to the medications I have tried
- ☐ the change that has occurred in this patient's usual headache pattern
- ☐ the patient's over-use of medication
- ☐ the possibility of a brain tumour
- ☐ the possibility of a cerebral aneurysm patient
- ☐ other _____

D. Is there a history of HEAD or NECK injury or surgery, FIBROMYALGIA, CHRONIC FATIGUE, CHRONIC PAIN SYNDROME or DEPRESSION?

- ☐ YES (circle which above)
- ☐ NO

E. Is the patient involved in MEDICAL/LEGAL proceedings, a DISABILITY CLAIM, or a WCB claim?

- ☐ YES (circle which above)
- ☐ NO

F. Has this patient been seen by specialists for his/her headache problem?

- ☐ NO
- ☐ YES (please APPEND COPIES of all consultation notes and results of any investigations)

G. Has this patient had an MRI or a CT scan?

- ☐ NO
- ☐ YES (please APPEND COPIES of all reports)

H. For how long has the patient had headaches?
_____ years or
_____ months

I. Have the patient's headaches changed in the last year?

- ☐ NO
- ☐ YES (check as many as apply)
  - ☐ increased in severity (please describe change)
  - ☐ increased in frequency (please describe change)
  - ☐ changed in character (please describe change)
  - ☐ other (please describe)

J. Which of the following time frames is MEDICALLY appropriate for your patient's appointment?

- ☐ next 2-6 weeks (PLEASE CALL DR. COOPER DIRECTLY AND DISCUSS PATIENT WITH HIM)
- ☐ before 18 months (ask patient to call my office after they have received their appointment date to be put on a CANCELLATION LIST)

H. Other pertinent information of which you feel we should be aware (please attach).

REFERRAL PROCESS: Not all patient referrals are appropriate for the Headache Clinic and you will be notified of whether you patient will be accepted for referral or not.

ALL other patients will be mailed an appointment date (> 2 yrs waiting time) and a questionnaire to complete and bring to their appointment.