USmigraine
Home of the Reed Procedure ®

Referral Form

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: _____

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Referral Date: ____ / ____ / _____

ADDITIONAL PATIENT INFORMATION

Preferred Name: _____

Gender : _____ Pronouns: He/Him | She/Her | They/Them | Other: _____

Interpreter required: Yes | No Language spoken: _____

Healthcare card number / Health insurance: _____

REFERRING PROVIDER INFORMATION

Name:_____ Telephone: _____

Fax:_____ Address:_____

Headache working diagnosis: _____

Headache History (include frequency number/day/week/month): _____

_____

_____

Previous neuroimaging: Yes (attach report) No

Prior headache/pain specialist seen: _____

Current medications (List all prescription and non-prescription):

_____

_____

Medication	Dose	Date Started
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

OPIOID USE: Yes If yes, quantity prescribed per month? _____ No

Previous headache medications tried and outcomes:_____

Medication	Date Tried	Outcome
	DD / MM / YYYY	
	DD / MM / YYYY	
	DD / MM / YYYY	

Medical/psychiatric/social history: _____

_____

_____

Please attach clinical notes and demographics.
If no standard headache therapies have been tried, the referral will likely be rejected.

Signature: _____

Send completed form to: **info@usmigraine.com**
If you have any questions, please call: **(866) 963-1109**