Therapeutic BOTOX® Centre REFERRAL FORM

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Patient Name _____ Daytime Number _____

DOB (MM/DD/YR) __ / __/____ Health Card _____ VC_____

☐ **REFERRAL FOR CHRONIC MIGRAINES**

Criteria for use of Botox® for Chronic Migraine

- Chronic Migraine diagnosed (secondary causes ruled out, > 15 headaches days per month with > 8 days having migraine features.
- Patient has had unsatisfactory prophylaxis or not suitable for 1-2 other prophylactic interventions.
- Patient is amenable to try this alternative therapy
- Patient has a drug plan to cover the cost of the Botox® Drug or prepared to pay cost privately.

☐ **REFERRAL FOR FOCAL HYPERHIDROSIS**

Criteria for use of Botox® for Focal Hyperhidrosis

- Must have focal hyperhidrosis sweating of (circle one) Underarms, Hands, Feet, Scalp, Groin or Inframammary
- Does not have generalized hyperhidrosis
- Patient is amenable to try this alternative therapy
- Patient has a drug plan to cover the cost of the Botox® Drug or prepared to pay cost privately.

Brief Clinical Summary_____
_____
_____

Prior Prophylactic Treatment and Outcome: _____
_____
_____

Referring Physician: _____OHIP Billing # _____
FHN/FHO MDs circle one to avoid OHIP billing negation FHO or FHN

Signature: _____ Date: _____