NORTH QUEENSLAND
neurology

**Specialist in Neurology and Neurophysiology**

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# MIGRAINE REFERRAL

**Patient Details**

Name: DOB:

Address:

Phone: Mobile:

Email:

**Please tick boxes that apply:**

☐ 15 or more headaches per month

☐ 8 of the headaches have migraine features

☐ Headaches have been on-going for at least 6 months

**Inadequate response, intolerance or contraindication to at least 3 migraine prophylactic medications:**

☐ Propranolol (Deralin, Inderal)
☐ Pizotifen (Sandomigran)
☐ Methysergide (Deseril)
☐ Cyproheptadine (Periactin)
☐ Amitriptyline (Endep)
☐ Topiramate (Topamax)
☐ Other

**Referring Doctor Details:**

Name:

Provider No:

Signature:

Date:

PROVIDER STAMP