Deon Louw, MB ChB FRCSC

Caleo Health, 1402 – 8th Ave. NW, Suite 200 Calgary, AB T2N 1B9

Phone: 403-452-5608;Fax: 403-984-5445

October 9, 2013

NOTICE: Neurosurgeon specialist accepting referrals for Frequent Migraines in Calgary Area

Dear Physician,

Caleo Health has moved to 200-1402 8th Ave NW, Calgary.

The new facility has increased my capacity to accept referrals for Chronic Migraineurs *(experiencing ≥15 headache days/month with ≥8 being migrainous)* who are willing to undergo BOTOX treatment. I've implemented a priority referral system to help minimize wait times for patients amenable to BOTOX treatment. Patients who should be considered for BOTOX treatment are those on existing prophylaxis and/or daily medication to prevent headaches.

Caleo Health does not charge patients an assessment or injection fee and BOTOX is covered by most insurance plans.

BOTOX received approval from Health Canada in late 2011 for the *prophylaxis of Chronic Migraine*.

Phone or Fax to Refer your Patients:

Phone: 403-452-5608

Fax: 403-984-5445 (Primary)
or
Fax: 403-452-0995 (Secondary)

In your referral, please include:

- **Referral form completed by the Physician & Patient.**

Should you have any questions, please do not hesitate to contact me.

Sincerely,

Deon Louw, MB ChB FRCSC

Botox for Chronic Migraine Referral Form Fax to: Caleo Health, 403-984-5445

Referring Physician Information (Please Print)			
Name:	Required - Mandatory	**PRACID #:**	Required - Mandatory
Address:		**Phone:**	
		Fax:	
Indication for Referral:			
Has this patient undergone Cranial Imaging? Yes ☐ No ☐ If Yes please attach reports			
Physician Signature:	X _____		

Section to be completed by Patient:

Name: _____ **DOB (DD/MM/YYYY): _____**

Address: _____ **Daytime Phone #: _____**

Health Card #: _____ *(or attach label with patient information)*

Do you have an active claim with WCB for this headache condition? Yes ☐ No ☐

Do you have an active insurance or legal claim for this headache condition? Yes ☐ No ☐

How many days in the past month were you *headache-free?* _____ (days)	**How many days in the past month did you have migraine** (include any days you took a triptan/ergot and had relief)**? _____ (days)**

When you have Migraine, what symptoms do you have (check all that apply)?

One side of your head ☐ Both sides of your head ☐ Pulsating/Throbbing ☐ Light sensitivity ☐

Moderate to Severe Pain ☐ Aggravated by / causing you to avoid physical activity ☐ Nausea and / or Vomiting ☐

Do you have difficulty swallowing? Yes ☐ No ☐ Have you been diagnosed with Myasthenia Gravis? Yes ☐ No ☐

Have you had Botox in the past for headaches? Yes ☐ No ☐ or other Botox treatment in the past three months? Yes ☐ No ☐

If "yes" when was your last treatment (DD/MM/YYYY)? _____ are you willing to undergo Botox injections? Yes ☐ No ☐

What medications are you currently taking?

What medications have you taken *in the past* for your migraines?

Did your headaches respond to any triptan or ergot medications? Yes ☐ No ☐

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www.caleohealth.ca