

**Deon Louw, MB ChB FRCSC**

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

Phone: 403-452-6876; Fax: 403-984-5469

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

Dear Physician,

Caleo Health has moved to 200-1402 8<sup>th</sup> Ave NW, Calgary.

The new facility has increased my capacity to accept referrals for Chronic Migraineurs (*experiencing  $\geq 15$  headache days/month with  $\geq 8$  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: 403-452-6876

Fax: 403-984-5469 (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, 403-984-5469**

Referring Physician Information (Please Print)			
Name:	Required - Mandatory	PRACID #:	Required - Mandatory
Address:		Phone:	
		Fax:	
Indication for Referral:			
Has this patient undergone Cranial Imaging? Yes <input type="checkbox"/> No <input type="checkbox"/> 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)
Is your headache the result of an MVA? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have an active insurance, WCB or legal claim for this headache condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	
How many days in the past month were you completely <i>headache-free</i> ? i.e. crystal- clear days _____	How many days in the past month did you have <b>migraine</b> (include any days you took a triptan/ergot and had relief)? _____ (days)
<b>When you have Migraine, what symptoms do you have (check all that apply)?</b>	
One side of your head <input type="checkbox"/> Both sides of your head <input type="checkbox"/> Pulsating/Throbbing <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Moderate to Severe Pain <input type="checkbox"/> Aggravated by / causing you to avoid physical activity <input type="checkbox"/> Nausea and / or Vomiting <input type="checkbox"/>	
Do you have difficulty swallowing? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you been diagnosed with Myasthenia Gravis or GBS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you had Botox in the past for headaches? Yes <input type="checkbox"/> No <input type="checkbox"/> or other Botox treatment in the past three months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If "yes" when was your last treatment (DD/MM/YYYY)? _____ are you willing to undergo Botox injections? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have a drug insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	
What medications are you currently taking?	
What medications have you taken <i>in the past</i> for your migraines?	
Did your headaches respond to any triptan or ergot medications? Yes <input type="checkbox"/> No <input type="checkbox"/>	