

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

**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: 403-452-6876

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

Migraine Referral Form: Fax to Dr. Deon Louw (Neurosurgeon and Headache Specialist)
Caleo Health Headache Clinic, Fax No: 403.984.5469

Referring Physician Information (Please Print)			
Name:		PRACID #:	
Address:		Phone:	
		Fax:	
Physician Signature:			
BOTOX FOR CHRONIC MIGRAINE		BOTOX FOR TMJ DYSFUNCTION	

Patient Information

Name: _____	DOB (DD/MM/YYYY): _____
Address: _____	Daytime Phone #: _____
Health Card #: _____ (or attach label with patient information)	
Is your headache the result of a motor vehicle accident (MVA)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have an active 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 headache-free? i.e. crystal-clear days: _____	
Have you seen a neurologist/headache specialist? YES <input type="checkbox"/> NO <input type="checkbox"/>	
When you have headache, what symptoms do you have (check all that apply)?	
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"/>	
What over-the-counter and prescription medications are you currently taking for headache?	
Have you taken any of the following medications (select all that apply):	
Amitriptyline <input type="checkbox"/> Topiramate <input type="checkbox"/> Propranolol <input type="checkbox"/> Candesartan <input type="checkbox"/> Gabapentin <input type="checkbox"/> BOTOX <input type="checkbox"/>	