THE UNIVERSITY OF BRITISH COLUMBIA

Tel: 604 822-1728
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S127 –2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5

BOTOX for Migraine Consultation Request

Please fax completed form to 604-822-7004

Patient name: _____

Birth date (DD MM YYYY): _____

Health card #: _____

Address: _____

Phone number (daytime): _____

Typically, for a patient to be considered a good candidate for BOTOX injections:

- ☐ **Patient has been tried on at least one (1) triptan**
- ☐ **Patient has been tried on a prophylactic medication (beta blocker, calcium channel blocker, TCA, anticonvulsant)**
- ☐ **Diagnosed with Chronic Migraine** (>15 headache days/month with >8 being migrainous); *and*
- ☐ **Has private insurance or is willing to pay for treatment**

***As part of the referral, please attach relevant medical notes**, including previous medications tried, results and any relevant medical imaging*

Referring physician (please print): _____

Physician MSP #: _____

Clinic phone #: _____

Referring physician signature: _____