THERAPEUTIC BOTOX REFERRAL FORM
FOR CHRONIC MIGRAINE, HYPERHIDROSIS, TMJ

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Patient Name (print) _____ Phone Number (Daytime) _____

Date of Birth (DD/MM/YYYY) _____ Health Card # _____VC_____

☐ **REFERRAL FOR CHRONIC MIGRAINES**

Criteria for use of Botox® for Chronic Migraine

- Chronic Migraine diagnosed (secondary causes ruled out) , > 15 headaches days per month with > 8 days having migraine features.
- Patient has had unsatisfactory prophylaxis or not suitable for 1-2 other prophylactic interventions.
- Patient is amenable to try this alternative therapy
- Patient has a drug plan to cover the cost of the Botox® Drug or prepared to pay cost privately.

☐ **REFERRAL FOR FOCAL HYPERHIDROSIS**

Criteria for use of Botox® for Focal Hyperhidrosis

- Must have focal hyperhidrosis sweating of (circle one) Underarms, Hands, Feet, Scalp or Groin
- Does not generalized hyperhidrosis
- Patient is amenable to try this alternative therapy
- Patient has a drug plan to cover the cost of the Botox® Drug or prepared to pay cost privately.

☐ **REFERRAL FOR TMJ**

Criteria for use of Botox® for TMJ (this is an off label treatment)

- Patient is diagnosed with Temporomandibular Joint Disorder
- Patient has failed (or is not suitable) with other traditional interventions
- Patient is amenable to try this alternative therapy
- Patient has a drug plan to cover the cost of the Botox® Drug or prepared to pay cost privately.

Brief Clinical Summary: _____
_____
_____

Prior Prophylactic Treatment and outcome: _____
_____
_____

Referring Physician: _____ OHIP Billing # _____

FHN/FHO MDs circle one to avoid OHIP billing negation (FHO or FHN?)

Signature _____ Date _____