Botox Referral Form (Chronic Migraines)

357 Flatbush Ave • Brooklyn, NY 11238
Ph (718) 230-3535 • Fax (718) 230-0596 • Alt Fax (718) 230-0390

SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑ M ❑ F
Patient Address: (include apt. #)			City:	State: Zip:
Home Phone:	Work Phone:		Cell Phone:	Primary Language:

PHARMACY INSURANCEINFORMATION:

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

****Please include a copy of the front and back of the patient's pharmacy insurance card with this form****

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician DEA # :	Physician NPI #:	License #:

CLINICAL INFORMATION:

Diagnosis:
- ❑ G43.709 - Chronic migraine without aura, not intractable, without status migrainous
- ❑ G43.719 - Chronic migraine without aura, intractable, without status migrainous
- ❑ G43.701 - Chronic migraine without aura, not intractable, with status migrainous
- ❑ G43.711 - Chronic migraine without aura, intractable, with status migrainous
- ❑ Other: ______________________

Allergies:

Med List:

Height: ❑in ❑cm

Weight: ❑lb ❑kg

History of Headaches *Date migraines started:*	*Baseline*	*Current*	*Reduction from baseline*
Number of headache days per month *(When determining number of headache days, it may be beneficial to ask the patient how many headache-free days each month the patient is experienceing.)*			
Number of headache hours per day			

❑ Moderate or severe pain intensity ❑ Nausea ❑ Vomitting ❑ Photophobia ❑ Phonophobia ❑ Unilateral ❑ Pulsating

Other Considerations	**Describe *(frequency, type, etc.)***
Disability dye to headache/migraine (e.g. work, school)?	
ER visit(s) due to headache/migraine?	
Other:	

Prophylactic Drug Class Prescribed	*Drug Name*	*Dose*	*Duration*	*Outcome*
❑ Antidepressant ❑ Antiepileptic/Anticonvulsant ❑ Beta-blocker ❑ Calcium Channel Blocker ❑ ACE Inhibitor/Angiotensin II Receptor Blocker				❑ Effective ❑ Suboptimal ❑ Intolerant ❑ Failed ❑ Contraindicated
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Acute/Abortive Drug Class Prescribed	*Drug Name*	*Dose*	*Duration*	*Outcome*
❑ NSAID ❑ Ergot alkaloid derivative ❑ Triptan ❑ Combination/other				❑ Effective ❑ Suboptimal ❑ Intolerant ❑ Failed ❑ Contraindicated
❑ NSAID ❑ Ergot alkaloid derivative ❑ Triptan ❑ Combination/other				❑ Effective ❑ Suboptimal ❑ Intolerant ❑ Failed ❑ Contraindicated

****Please include an original prescription with this form or E scribe a prescription to Kings Pharmacy****

PRESCRIBER SIGNATURE: **DATE:**