



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:	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Provider's Office	<input type="checkbox"/> Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient Address: (include apt. #)			City:	State: Zip:
Home Phone:	Work Phone:	Cell Phone:		Primary Language:

PHARMACY INSURANCE INFORMATION:

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: <input type="checkbox"/> G43.709 - Chronic migraine without aura, not intractable, without status migrainous <input type="checkbox"/> G43.719 - Chronic migraine without aura, intractable, without status migrainous <input type="checkbox"/> G43.701 - Chronic migraine without aura, not intractable, with status migrainous <input type="checkbox"/> G43.711 - Chronic migraine without aura, intractable, with status migrainous <input type="checkbox"/> Other: _____	Allergies:
	Med List:
	Height: <input type="checkbox"/> in <input type="checkbox"/> cm
	Weight: <input type="checkbox"/> lb <input type="checkbox"/> kg

History of Headaches	Date migraines started:	Baseline	Current	Reduction from baseline
Number of headache days per month <i>(When determining number of headache days, it may be beneficial to ask the patient how many headache-free days each month the patient is experiencing.)</i>				
Number of headache hours per day				
<input type="checkbox"/> Moderate or severe pain intensity <input type="checkbox"/> Nausea <input type="checkbox"/> Vomitting <input type="checkbox"/> Photophobia <input type="checkbox"/> Phonophobia <input type="checkbox"/> Unilateral <input type="checkbox"/> Pulsating				

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

Prophylactic Drug Class Prescribed	Drug Name	Dose	Duration	Outcome
<input type="checkbox"/> Antidepressant <input type="checkbox"/> Antiepileptic/Anticonvulsant <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Calcium Channel Blocker <input type="checkbox"/> ACE Inhibitor/Angiotensin II Receptor Blocker				<input type="checkbox"/> Effective <input type="checkbox"/> Suboptimal <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> Contraindicated
<input type="checkbox"/> Antidepressant <input type="checkbox"/> Antiepileptic/Anticonvulsant <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Calcium Channel Blocker <input type="checkbox"/> ACE Inhibitor/Angiotensin II Receptor Blocker				<input type="checkbox"/> Effective <input type="checkbox"/> Suboptimal <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> Contraindicated
<input type="checkbox"/> Antidepressant <input type="checkbox"/> Antiepileptic/Anticonvulsant <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Calcium Channel Blocker <input type="checkbox"/> ACE Inhibitor/Angiotensin II Receptor Blocker				<input type="checkbox"/> Effective <input type="checkbox"/> Suboptimal <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> Contraindicated

Acute/Abortive Drug Class Prescribed	Drug Name	Dose	Duration	Outcome
<input type="checkbox"/> NSAID <input type="checkbox"/> Ergot alkaloid derivative <input type="checkbox"/> Triptan <input type="checkbox"/> Combination/other				<input type="checkbox"/> Effective <input type="checkbox"/> Suboptimal <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> Contraindicated
<input type="checkbox"/> NSAID <input type="checkbox"/> Ergot alkaloid derivative <input type="checkbox"/> Triptan <input type="checkbox"/> Combination/other				<input type="checkbox"/> Effective <input type="checkbox"/> Suboptimal <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> Contraindicated

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

PRESCRIBER SIGNATURE:	DATE:
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