Chronic migraine solutions
T: 1800 321 789
E: info@migrainedoctor.com.au

migraine doctor

Referral form via Migraine Doctor

Patient details:

Patient name: .....

Date of birth: .....

Referral date: .....

Email: .....

Phone .....

State: .....

GP details:

Referring Dr: .....

Dr address: .....

Tel: .....

Fax: .....

Provider No: .....

Signature: .....

Does your patient have chronic migraine?

- ☐ ≥15 headache days a month
- ☐ ≥8 migraine
- ☐ ≥3months?

List the prophylactic medication that this patient has tried:

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Clinical notes:

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