**Adult Headache Including Chronic & Episodic Migraine Referral Form**

**PILOT VERSION**

**Maidstone & Tunbridge Wells Headache Referrals Project**

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| **Patient Details** |
| Name:  | NHS Number: |
| Address:  | Post Code: |
| Daytime Telephone:  | Date of Birth:  |
| Work Telephone:  | Interpreter Required: Y/N |
| Mobile Telephone:  | If yes, main spoken language: |
| **GP Details** |
| GP Name:  | Telephone Number:  |
| Practice:  | Date of Referral:  |

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| History of headache complaint |

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| **Reason for referral**  |
| [ ] Failed prophylactic response\* [ ]  Advice and guidance re: diagnosis and treatment \***The patient with migraine needs to have tried at least THREE different prophylactic drugs (at maximum tolerated dose)for at least TWO months each if tolerable before consideration for referral for specialist treatment (Please refer to the** [**Kent and Medway guidance on the management of adults with headaches and migraines in primary care**](https://www.formularywkccgmtw.co.uk/media/1782/km-management-of-adults-with-headaches-and-migraines-in-primary-care.pdf)**)** |

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| **Headache history** |
| [ ] 1 month to 1 year [ ]  More than 1 year |
| **Headache frequency** |
| [ ]  <1 day per week [ ]  1-2 days per week [ ]  >2 days per week  |

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| --- | --- | --- |
| **Prophylaxis treatment already tried** | **Maximum Dose tolerated** | **Treatment duration** |
|  [ ]  Propranolol 80-240mg/day  |  |  |
|  [ ]  Amitriptyline 10-75mg/day  |  |  |
|  [ ]  Topiramate 25-200mg/day  |  |  |
|  [ ]  Candersartan 4mg-32mg/day |  |  |
|  [ ]  Other – please specify in line with approved guidance |  |  |

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| **Analgesia overuse**  |
| Analgesia overuse present? – Y/N/Uncertain*(Acute analgesics should be used fewer than 10 days per month or two days a week, to avoid development of ‘medication overuse headache’. Prophylactics may fail unless analgesic use is reduced.)* |
| If Y, list name and duration  |

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| **Important information/resources** |  **Y** |  **N** |
| Attach any brain imaging report if available *(tick Y if attached)* |  |  |
| If possible attach patient’s headache diary *(tick Y if attached).* *Example at* <https://migrainetrust.org/live-with-migraine/self-management/keeping-a-migraine-diary/> |  |  |
| Has the patient been signposted to [www.migrainetrust.org](http://www.migrainetrust.org) for information? |  |  |
| Have you considered referring to headache guidelines from any of: [Kent and Medway CCG](https://www.dgsdvhformulary.nhs.uk/media/1079/management-of-adults-with-headaches-and-migraines-in-primary-care-20.pdf) / BASH [bash.org.uk/guidelines](https://www.bash.org.uk/guidelines/) / SIGN [sign.ac.uk/sign-155-migraine](https://www.sign.ac.uk/sign-155-migraine) ?  |  |  |

**Please upload this form to the referral via eRS. Completion of this form is now a mandatory part of headache referral to MTW, please be advised referrals not sent using this form may be declined.**