**South West London Regional Headache Referral Form**

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| **Patient Details** |
| Name: Full Name  | Date of Birth: Date of Birth  |
| Address: Home Full Address (single line)  | Sex: Gender(full) |
| Post Code: Home Address Postcode  | Ethnicity: Ethnic Origin  |
| Interpreter Required: Y/N | NHS Number: NHS Number  |
| Please tick preferred contact number ✓ | Hospital Number:       |
| Daytime Telephone: Patient Home Telephone  | [ ]  | UBRN:       |
| Work Telephone: Patient Work Telephone  | [ ]  | First Language: Main Language |
| Mobile Telephone: Patient Mobile Telephone  | [ ]  | Interpreter Required:  | [ ]  (tick if Yes) |
| **GP Details** |
| GP Name: Current User       | Telephone Number: Organisation Telephone Number |
| Practice: Organisation Name | Date of Referral: Short date letter merged       |

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| **IMPORTANT: This section must be completed for compliance under the Equality Act (2010)****Cognitive, Sensory or Mobility Impairment**Sight Impaired (Blind) [ ]  Sight Impaired (Partially sighted) [ ]  Hearing Impaired (Deaf) [ ]  Hearing Loss (Partial) [ ]  Speech Impaired [ ]  Learning Disability [ ]  Autism [ ]  Mobility [ ]  Mental Health [ ]  Dementia [ ]  **Need related to:** Age, Religion/Belief, Sexual Orientation, Disability, Gender, Gender Reassignment, Race, Pregnancy and Maternity, Marriage and Civil Partnership [ ]  Armed Forces [ ]  Other [ ]  None [ ]  **IMPORTANT: Please describe relevant need to guide patient communication process**Please include relevant details:**Barriers that would prevent patient from taking part in telephone or video consultation:**No [ ]  Yes [ ]  Connectivity – bad signal [ ]  Other [ ]   No access to smart phone [ ]  Please describe: **IMPORTANT: Please identify reasonable adjustments to enable virtual access** Carer or other needed to be present to help [ ]  Text Relay [ ]  BSL [ ]  Communication passport – eg easy read / visuals, longer appointment slot [ ]  Please include others / relevant details:  |

**PLEASE USE THE SOUTH WEST LONDON HEADACHE PATHWAY TO HELP YOU COMPLETE THIS FORM:**

**Available at ……………………..**

**THIS SERVICE IS FOR GREEN PATHWAY PATIENTS ONLY. IF RED OR AMBER PLEASE SEE…. OR CONTACT….FOR ADVICE AND GUIDANCE**

*Please ensure that you complete this form in full when you make a referral to the regional headache service – the information you provide us on this form will help the consultant make an informed decision on the patient’s care.*

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| **If the answers to any of these questions in this section are yes, please refer via the ED/Ambulatory / Hot clinic / 2 week rule as per the pathway / Eye Clinic (Discuss via advice and guidance/Kinesis/mobile)** |
|  | **Yes** |
| Thunderclap headache (<5 minutes to maximum severity) |  |
| Acute headache with loss of consciousness |  |
| Headache with systemic features (eg hypertension, meningism, fever) |  |
| Headache in age>50 +/- ESR>50 with visual symptoms |  |
| Red eye |  |
| Headache with focal neurology/seizures/ personality change |  |
| Headache with swollen discs |  |
| New headache with recent head trauma within last 3 months |  |
| New headache in 3rd trimester of pregnancy / early post-partum |  |
| New headache in existing cancer / immunocompromised |  |
| Postural headaches |  |

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| **Reason for referral (More than one option may be selected)** |
| **[ ]** Uncertain diagnosis **[ ]** Ineffective treatment**[ ]**  Patient requests referral **[ ]** Self-Management help**[ ]** Advice and guidance**\* [ ]**  Other (please specify)………………….. |
| **Headache onset** |
| **[ ]** Less than 1 month **[ ]** 1-month to 1 year **[ ]** More than 1 year |
| **Headache diagnosis (More than one option may be selected)** |
| **[ ]** Migraine [ ]  Cluster headache [ ]  Analgesic overuse [ ]  Tension type headache [ ]  Traumatic brain injury (over 3 months ) [ ]  Unsure **[ ]** Other…………………. |
| **Headache Frequency**  |
| **Has the patient completed a headache diary? [ ]** Yes  **[ ]** No <https://www.stgeorges.nhs.uk/wp-content/uploads/2014/11/SGH-Monthly-Headache-Diary.pdf>[ ]  <8 days per month [ ]  8-15 days per month [ ]  >15 days per month  |
| **Has the patient visited the surgery/ ED more than 3 times for headache?** |
| **[ ]** Yes  **[ ]**  No If yes, number of visits………………. |
| **Examination** |
|  **[ ]**  Normal **[ ]**  Abnormal **If abnormal, please specify:**…………………………………… |
| **Any previous imaging completed?** |
| **[ ]** Yes  **[ ]**  No |
| **If Yes:****[ ]** MRI  **[ ]** CT **Date:**……………….. **[ ]** Normal **[ ]** Abnormal**Details:** |
| **Preventative treatment tried?** |
| **[ ]** Propranolol [ ]  Amitriptyline [ ]  Topiramate [ ]  Candesartan [ ]  Other……………… |
| **Additional relevant drug history (including max dose of migraine preventers)** |
|  |
| **Past medical history** |
|  |
| **Additional Info/comments** |
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Patient information leaflets available at:

*\*If you have ticked that you require advice and guidance a headache specialist will be in contact with you within 48 hours via telephone or e-mail.*