**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:**………………..  NormalAbnormal  **Details:** |
| **Preventative treatment tried?** |
| Propranolol  Amitriptyline  Topiramate  Candesartan  Other……………… |
| **Additional relevant drug history (including max dose of migraine preventers)** |
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| **Past medical history** |
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| **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.*