NIAGARA CENTRE FOR
HEADACHE AND GENERAL NEUROLOGY

Tasjeel Ansari, MD, FRCP(C), DABPN – Neurology
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Headache/General Neurology Clinic Referral Form

To best serve you within a reasonable time frame, please have this form filled out completely and legibly.
Incomplete and/or illegible forms will be returned.

Date: _____

PATIENT INFORMATION: Niagara Health MRN (if available): _____

Name: _____

Address:_____

DOB (MM/DD/YYYY): _____/_____/_____

Sex: M ☐ F ☐ Other (please specify):

Contact Phone Number(s): Home: _____ Mobile: _____ Email Address (*optional*):_____

Health Card Number (***required***): _____VC: _____

English speaking: Yes:◯ No:◯
If patient does not speak English, a family member/friend must attend all appointments.

HEADACHE HISTORY:

Current Headache Diagnosis: _____

Number Headache days a month: 0-6 days a month◯ 7-14 days a month◯ ≥15 days a month◯

Acute medications tried (e.g NSAID, Gepant, Triptan): _____

Preventive treatments attempted (e.g., antihypertensive, anti-seizure, Botox, anti-CGRP, etc.):

_____

Reason for not trying preventive treatment (if applicable): _____

Opioid Use: Yes◯ No◯; If yes, quantity prescribed per month: _____

FURTHER HEADACHE HISTORY:

Insurance: Public (e.g. OW, Trillium, ODSP):◯ Private:◯ None:◯

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LEVEL OF URGENCY: Next Available:◯ Semi Urgent*:◯ Urgent*(Please contact our office):◯

**Please state reason for urgency:* _____

PAST MEDICAL HISTORY:

PREVIOUS NEUROIMAGING (MRI/CT): Yes (please attach report):◯ No:◯

If no, provide reason/comments: _____

Please include list of current medications, results of previous investigations, recent imaging, recent bloodwork, management, and consult & follow-up notes relevant to this referral.

*If applicable, please indicate the name and date of last assessment by a neurologist (inpatient/ER/clinic):

_____

*If applicable, please indicate the name and date of last assessment by a pain specialist:

_____

REFERRING PHYSICIAN INFORMATION:

Source**:** Family MD:◯ Neurologist:◯ Other (Please Describe): _____

Name: _____

OHIP Provider Number/Billing Number (***required***): _____

Address: _____

Phone Number: _____ Fax Number: _____

Confidential Email (*optional*): _____

Referring Physician Signature ***(required)***: _____

If the referring physician is not the family physician, please fill out the following information:

Family MD Name: _____ Family MD Fax Number: _____

FOR OFFICE USE ONLY	
Date Received:	Approved By:
Triage Level:	

RESET FORM