

Neurology Headache Referral Proforma

| Patient Details | | | GP Details | | |
|-----------------|--|--------|------------|-------------------|--|
| Name | | | | GP Name: | |
| Address | | | | Surgery | |
| Post Code | | | | Tel: | |
| DOB | | | | Fax | |
| Tel No | | mobile | | Practice Code: | |
| NHS No. | | | | Date of Referral: | |

| Protocol Referral Reason | Tick | |
|--------------------------|------|---|
| Red Flag | | |
| Refractory headache | | (no response to treatments recommended in headache algorithm) |
| Cluster Headache | | |
| I cannot diagnose it | | (e.g. undifferentiated headache, rare headache syndrome) |
| Non protocol referral | | Explain reason for non-protocol referral: |
| | | |

| Enter results for <u>all</u> patients aged ≥ 50 years, <u>OR</u> tick 'not relevant' if definitely not giant cell arteritis | | | | | | |
|--|--|--|-----|--|------------------------|--|
| ESR | | | CRP | | ESR & CRP not relevant | |

| Red Flag Indicators (see 2WW form for more urgent indicators) Please complete the following questions in addition to the other sections of this form | | | | |
|---|---|--|-----|----|
| | | | Yes | No |
| 1 | Over 50 and suffering from a new headache whose onset was less than 6 months ago? | | | |
| 2 | Suffering from headache increasing in severity and frequency over the last 6 months despite appropriate treatment? | | | |
| 3 | Suffering from undifferentiated headache (not migraine / tension headache) of recent origin and present for longer than 8 weeks | | | |
| 4 | Suffering with a new onset headache in immunosuppressed or HIV | | | |

| Other Blood Results (for all undiagnosed headaches) | | | |
|---|--|--|--|
| Hb | | | |
| Corrected Calcium | | | |
| TFT | | | |

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| Blood Pressure | |
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| Headache History: (include duration, frequency and characteristics e.g. nature and location of pain and associated symptoms) |
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| Headache Medication: Detail acute and prophylactics including dose and duration of treatment |
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| Other medication |
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| Past Medical History |
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| Contra-indications to MR scanning e.g. pregnancy / claustrophobia / pace-maker / metal foreign bodies / disabilities |
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|---------------------------|-----|--------------------------|----|--------------------------|
| Transport Required | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
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| Special Needs Requirements (e.g. Hoist / Interpreter etc) |
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Notes to Patient

- ✓ Please inform the patient they may receive an appointment for either a scan or to see a clinician
- ✓ Please note that referring GP's need to ensure the patient wants to be referred and understands that they will need to be treated within 18 Weeks