INOVO MEDICAL
1328 Labrie Ave, Ottawa, ON
K1B 3M1, (613) 749-4668

Dear Doctor,

INOVO MEDICAL is a Chronic Pain and Multidisciplinary Clinic currently accepting referrals for patients suffering from Chronic or Frequent Migraine.

Chronic or Frequent Migraine is a common neurological disorder that produces substantial disability for those who suffer. Studies have shown that more than 4.9 million Canadians are currently suffering with Episodic Migraine (8.3%- 10.2% of the population). Chronic Migraine prevalence estimates are reported to range from 2.2%- 2.5% among the general population, This number may however be widely underestimated given many still go undiagnosed. Misdiagnosis often occurs as neck pain and tension headaches are commonly not regarded as the “daily headache” component commonly occurring in Chronic Migraine sufferers. Approximately 60-80% of chronic migraine sufferers are overusing their acute medications which in turn contribute to Medication Overuse Headache (MOH).

BotoxOnabotulinumToxinA is a Health Canada approved therapy for the Prophylactic Treatment of Chronic Migraine Headache. It requires a short series of injections on the forehead, side/back of the head and shoulders. It is covered under almost all insurance plans and has recently been listed in the Exceptional Access Program under the Ontario Drug Benefits.

When referring a patient, please complete the attached **Referral Form** and fax it to us at 1-844-414-6686. We would encourage you to also complete the **Chronic Migraine Treatment History** Form if you have time, as the information will be helpful, however it is not required for admission to our clinic.

Included in this package are a few educational materials (Headache Diary and Information Sheet) you can provide to your patients.

We are pleased to offer the most competitive price in Ottawa for the injection procedure - starting at $125.00. This is billed directly to the patient as insurances rarely cover this cost. Please, note that we will assess and treat other comorbidities or exacerbating factors.

We look forward to treating your patients,

Mathieu Belanger, MD
CEO

Referral Form

INOVO MEDICAL CENTRE Fax: 1 844-41-INOVO
1328 Labrie Ave, Ottawa (1 844-414-6686)

BOTOX for Migraine Consultation Request

Please fax completed form

Patient name: _____

Birth date (DD MM YYYY): _____

Health card #: _____

Address: _____

Phone number (daytime): _____

Please check that patients being referred to the injection clinic meet these criteria:

- ☐ *Secondary headache causes have been ruled out*
- ☐ *Chronic Migraine (> 12 headache days/month with 2-3 features of migraine)*
- ☐ *Patient has insurance coverage for treatment or is willing to pay*
- ☐ *Relevant diagnostic or confirmatory tests performed:*
  - ☐ *Neurological Consult*
    *Date:*_____*Comments:*_____
  - ☐ *MRI/CT Scan*
    *Date:*_____*Comments:*_____

Referring physician (please print): _____

Physician OHIP #: _____

Clinic phone #: _____

Referring physician signature: _____

***Please note that Physicians belonging to a FHT, FHN and FHG will not be negated.*

FOR OFFICE USE ONLY

Date received: _____ **Appointment date:** _____ **Time:** _____

Chronic Migraine Treatment History

Patient Name:_____ Date of Birth(D/M/Y)_____

All Prior Relevant Treatment (Optional)

Prophylactics

☐Tricyclic antidepressants Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Ergots Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Anticonvulsants ☐Topiramate Drug Name:_____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Beta Blockers Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Calcium Channel Blockers Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing

At Risk for Medication Overuse Headache if any Combination totaling >9 days/month

☐Opiods Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Triptans Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐NSAIDS Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Acetaminophen Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Fiorinal _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing
☐Other Drug Name: _____	Maximum Dose: _____	Approximate Duration: _____	☐Effective	☐Ltd Benefit	☐Ineffective	☐Not Tolerated	☐Ongoing

Physician Signature_____

Track Your Progress

To assist you in doing so, use a simple Headache Diary such as this one. Make sure to fill it out as accurately and completely as possible every day and bring it with you to discuss with your doctor at your next visit.

HEADACHE DIARY

MONTH: _____

Part 1: Headache severity

(**0** = no pain; **10** = the worst pain you have experienced.)

Record the strength of your headache pain using an 11-point scale, where 0 = no pain and 10 = the worst pain you have experienced. Provide scores for different times of the day – morning, afternoon, and evening – to see how your headache pain changes.

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Morning																															
Afternoon																															
Evening																															

Part 2: Headache duration

(Mark with an "**X**" how long each headache lasted.)

Record how long your headaches last: less than 4 hours, 4 to 12 hours, or 13 to 24 hours.

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Less than 4 hours																															
4 to 12 hours																															
13 to 24 hours																															

Part 3: Headache symptoms

(Mark with an "**X**" any signs or symptoms experienced with each headache.)

Record all symptoms that accompany each headache. Choose from the list provided, or list any other symptoms in the space(s) noted "Other."

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aura																															
Nausea																															
Sensitivity to Light																															
Sensitivity to Sound																															
Inability to Work/Function																															
Throbbing																															
Other:																															
Other:																															
Other:																															

Part 4: Medication use

(Record the name and dose of medication used, if any.)

Record the name and dose of medication used, if any. This includes all acute and preventive medications, both over-the-counter and prescription.

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication 1 Name:																															
Dosage per day																															
Medication 2 Name:																															
Dosage per day																															
Medication 3 Name:																															
Dosage per day																															
Medication 4 Name:																															
Dosage per day																															

For more information and to register for a program designed specifically for the BOTOX® patient, visit www.BOTOX.ca and enter the drug identification number (DIN) 01981501. You can also visit this site to download a copy of the Headache Diary.

1. BOTOX® Product Monograph, Allergan Inc., December 21, 2011. 2. International Headache Society. The International Classification of Headache Disorders, 2nd Edition (ICHD-II). Part 1: The Primary Headaches. http://ihs-classification.org/en/02_klassifikation/02_teil1/, accessed June 20, 2011. 3. Olesen J, Bousser MG, Diener HC, et al. New appendix criteria open for a broader concept of chronic migraine. *Cephalalgia* 2006;26:742–746.

ALLERGAN PAAB

BOTOX® onabotulinumtoxinA

Migraines are not like other headaches.

PAIN is a part of every headache, but migraine pain is usually more severe – much worse than a common headache. Most people describe it as an intense throbbing pain on one side of the head.

After Headache Pain, Nausea Tops The List of Associated Migraine Symptoms.

Nausea is the symptom most commonly reported by migraine sufferers. Doctors often look for this symptom in making a diagnosis of migraine, as up to 90% of patients experience it at the very beginning of a migraine attack. Vomiting and visual problems such as sensitivity to light may also occur. Some people even experience warning signs called "auras", typically before the headache pain begins. The presence of aura can affect the way you see, including seeing zigzags or flashing lights and colours. Things may appear in different locations or appear distorted in size or shape.

According to the International Classification of Headache Disorders- III, The Definition of Chronic Migraine is headache on >15 days per month for 3 months.

Migraines Are More Common Than You May Think.

- It is estimated that 4.9 million Canadian adults suffer from migraines
- Over 75% of migraine sufferers are women, outnumbering men by about 3 to 1.
- The prevalence of migraine is highest during the ages of 25-55 years.

Stop The Migraine Before It Starts; Be Aware of Your Migraine Triggers.

Triggers are those things that are believed to bring on or provoke migraine attacks in some people. Avoiding your personal triggers may help you prevent migraine attaches or, at the very least, reduce the number or severity of attacks you get.

Although different people are sensitive to different triggers, the items listed here are among the ones likely to provoke a migraine attack. Check the triggers that belong on your personal list.

Migraine Triggers

FOOD AND DRINKS

- Ages Cheeses
- Certain fruits & vegetables
- Fermented, pickled foods
- Meats with Nitrites (most sandwich meats)
- Drinks containing alcohol or caffeine
- Foods high in concentrated sugar or
- Onions
- Chocolate
- Dairy or yeast products
- Monosodium glutamate
- (MSG- a food additive)
- Sulfites (a food additive)
- Certain Dyes (natural –beets, and artificial)
- Fasting
- Not having proteins at breakfast
- Dried Fruits
- Salty Foods –Including Nuts
- Artificial sweeteners (aspartame, saccharin)

HORMONAL CYCLES OR CHANGES

- Menstruation
- Hormonal replacement
- Oral Contraceptives
- Pregnancy
- Menopause
- Absence of menstruation

CHANGES IN THE WEATHER

EXPOSURE TO

- Strong odors (perfume, paint, cleaning solutions, exhaust fumes)
- Smoke
- Electronic screens from televisions, computers or smart phones.
- Scintillating, flashing, bright or fluorescent lighting

CHANGES IN BEHAVIOUR

- Sleeping more or less than usual
- Skipped or delayed meals
- Changes in diet
- Strong emotions or stress