



Name: _____

Address: _____

Phone Res: _____ Other: _____

Date of Birth: mm/dd/yyyy Age: _____ Male Female

PHN: _____ WCB (Y / N) Other: _____

Appointment Details

Date: _____

Time: _____

Clinic Location: _____

ALL EXAMINATIONS Please bring your Health Care card and another piece of identification with this form.

Locations Hys Medical Centre 202-11010 101 ST NW • Tawa Centre 200-3017 66 ST NW – *More locations to come*

Significant Clinical History

Date of L.M.P: _____

Pregnant: Yes No

Patient's Signature: _____

(requisition valid x 1 year from first appointment)

Please select from these patient indications:

- Chronic and Episodic Migraines Cluster Headaches Trigeminal Neuralgia and Neuritis Post Root Canal Pain
 Post Traumatic Facial Pain

Tension headaches are not responsive to SPG blocks.

Screening questionnaire to determine if your patient is an appropriate candidate for success with an SPG Block:

1. Do you have a headache at the present time? (If the answer is yes, please answer questions A through C)

- A. Is this your first severe headache? Yes No
 B. Is this the absolute worse headache you've ever experienced? Yes No
 C. Is this headache significantly different from any of your previous headache patterns? Yes No

If the answer to any of the above questions is **YES**, potential secondary causes of headache should be investigated and the patient should **not** be referred for an SPG block. **If all answers are NO, please continue.**

2. In cases where the indication is migraine or cluster headache:

- A. Are the headaches described as pulsing or throbbing? Yes No
 B. Does the intensity of the headache get worse with position (i.e. bending over)? Yes No
 C. Does the intensity of the headache increase with exertion? Yes No

If the answer to the above three questions is **NO**, the SPG block will **not likely** benefit your patient.

If YES, please continue.

3. How long has the patient been experiencing symptoms? _____

If less than 90 days, an SPG block may not yet be indicated until further workup.

4. What investigations have been completed to diagnose these headaches?

5. What medications are currently used for symptom/headache control?

The device required for this procedure is available from MIC at cost.

Practitioner's Name: _____

Practitioner's Address: _____

Clinic Ph: _____ Clinic Fax: _____

Copy to: _____ Fax Copy: _____

Signature: _____

Official Diagnostic Imaging Provider for:

Practitioner's Stamp
& Practice ID

