REQUEST FOR MRI or CT FOR THE EVALUATION OF HEADACHE

Please complete this form and ***include supporting clinical documentation***. CPMG cannot appropriately review your request without this information.

Date of Request: _____

Member Name: _____ **Member ID#:** _____ **DOB:** _____

Requesting Provider's Name: _____ **Specialty:** _____

Please answer the following questions:

1. **How long has the child been suffering from headache?**

2. **What is the frequency of the headache?**

3. **Does the child complain of other symptoms? (nausea, vomiting, photophobia, phonophobia, awakening from sleep with headache)**
   ☐ **Yes** ☐ **No**

   If so, list or circle all

4. **Is there a family history of migraine?** ☐ **Yes** ☐ **No**

5. **Abnormal neurologic exam?** ☐ **Yes** ☐ **No**

   - **Does the child have papilledema?** ☐ **Yes** ☐ **No**
   - **Does the child have abnormal eye movements and/or nystagmus?** ☐ **Yes** ☐ **No**
   - **Does the child have any motor or gait dysfunction?** ☐ **Yes** ☐ **No**

6. **Have you performed any other diagnostic test?** ☐ **Yes** ☐ **No**

   If so, please list:

   What were the results?

7. **If the child has been diagnosed with any illnesses or disorders, please list below:**

OTHER COMMENTS OR OBSERVATIONS:

Please attach this document and supporting clinical documentation to the CPMG request for authorization form and FAX to: CPMG CUSTOMER SERVICE at (858) 309-7977.