[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

RE: DISCHARGE FROM CHRONIC MIGRAINE CLINIC

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Dear [Recipient Name/GP Name],

This letter is to confirm that [Patient Name] has been formally discharged from the Chronic Migraine Clinic effective [Discharge Date].

Reason for Discharge:
[e.g., Clinical stability achieved / Completed treatment protocol / Non-attendance / Patient request]

Diagnosis:
[Specific Diagnosis, e.g., Chronic Migraine with/without Aura]

Treatment History & Response:
[Summary of interventions, such as Botox, CGRP inhibitors, or preventive medications, and the patient's response to these treatments].

Current Medication Regimen:
Preventative: [Medication Name, Dosage, Frequency]
Acute/Rescue: [Medication Name, Dosage, Frequency]

Discharge Recommendations:
1. [Management plan for Primary Care]
2. [Lifestyle recommendations]
3. [Medication titration or maintenance instructions]

Follow-up Plan:
The patient has been advised to follow up with their Primary Care Physician for ongoing prescription management. A re-referral may be submitted if the patient experiences a significant increase in headache frequency or if current treatments become ineffective.

Sincerely,

[Doctor Name/Signature]
[Title/Position]