Stroke Prevention Clinic
PATIENT REFERRAL

FAX: 519-751-5837
Telephone: 519-751-5544 ext 2996

Name:
Address:
City:
Postal Code:
Home Phone:
Work or Alternate Phone:
Family Physician:
Health card #
Date of Birth:

Persons presenting with recent stroke symptoms and/or requiring emergency neurological consultation should be directed to the nearest Emergency Department.
The following form MUST be completed by the Referring Physician or Nurse Practitioner.

Patient/Caregiver BEST contact number: ________________

Reason for referral: ☐ TIA ☐ Stroke ☐ Carotid Stenosis
☐ Other: ____________________________

Date of Most Recent TIA/Stroke Event:

____
(dd/mm/yy)

Clinical Features: (Check (✓) all that apply)

☐ Unilateral weakness: ☐face ☐arm ☐leg (☐R ☐ L)
☐ Unilateral sensory loss: ☐face ☐arm ☐leg (☐R ☐ L)
☐ Speech disturbance (slurred or expressive/word finding difficulty)
☐ Amaurosis fugax (temporary loss of vision in one or both eyes)
☐ Other: ____________________________________

Duration of Symptoms: (Check (✓) most appropriate)

☐ Seconds
☐ Minutes OR ☐ greater than 10 min
☐ Hours
☐ Days

Frequency of Symptoms: ☐ Single episode ☐ Recurring/ Fluctuating

Risk Factors: (Check (✓) all that apply)

☐ History of Atrial Fibrillation ☐ Hypertension
☐ Hyperlipidemia ☐ Diabetes
☐ Ischemic Heart Disease ☐ Previous known Carotid disease
☐ Current or Past Smoker ☐ Previous Stroke or TIA

The following tests are required:

1. Computerized Tomography (CT) Head Non Contrast
2. Carotid Imaging
3. 12 Lead Electrocardiogram (ECG)
4. Bloodwork: HbA1C, lipid panel, creatinine, electrolytes, hepatic panel, CBC, INR, PTT, urea

Include " Stroke Prevention Clinic" on paper requisitions to ensure tests are completed urgently.

Treatment initiated: (Check (✓) all that apply)

☐ Antiplatelet therapy ______________________
☐ Anticoagulation: ______________________
☐ Antihypertensive(ACEI or ARB):
____

Key Best Practices:

* Acute Antiplatelet Therapy prevents stroke
* Identification of a moderate to high-grade (50-99%) stenosis on carotid ultrasound typically warrants urgent referral to a neurovascular surgeon for assessment of possible carotid endarterectomy.

Referred by: ____________________ ______________________ ____________ ____________

(Printed Name) (Signature and Designation) (Billing Number) Date (yyyy/mm/dd)

☐ **Family Physician** ☐ **ER Physician** ☐ **Hospitalist** ☐ **Specialist** ☐ **Nurse Practitioner**

FAX all test results, Emergency records, and this form to: 519-751-5837
Phone 519-751-5544 ext 2996 and leave message containing patient name and hospital number.
Do not delay referring to Stroke Prevention Clinic if tests are not completed or resulted.