



46 General Hospital Drive
 Stratford, ON N5A 2Y6
 519-272-8210 ext. 2299

Patient Name: _____
Address: _____
DOB: _____ **Age:** _____
Health Card #: _____
Telephone: _____

STROKE PREVENTION CLINIC REFERRAL FORM

Date of Event (TIA or MINOR STROKE): _____ **Alternate contact:** _____
 DD / MM / YYYY

<u>Signs/Symptoms:</u>	<u>Side (R/L)</u>	<u>Duration (mins)</u>
Unilateral motor deficit(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Unilateral numbness/tingling <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Aphasia <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Dysarthria <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Amaurosis Fugax <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Hemianopia <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Vertigo* <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

*Must be accompanied by one other symptom (e.g., dysarthria, diplopia, ataxia)

<u>Risk Factors:</u>
<input type="checkbox"/> Atherosclerosis
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Ischemic Heart Disease
<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Previous Stroke or TIA
<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Family Hx Stroke
<input type="checkbox"/> Depression

History/Comments: _____

<u>Investigation(s) (most recent):</u>	<u>Date:(dd/mm/yy) / Location</u>	<u>Medication(s) (include dose & frequency):</u>
Carotid Ultrasound <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> attach verified list of medications from ER triage or <input type="checkbox"/> attach verified list of medications and patient profile from family doctor _____ _____ _____
CT Head <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Echocardiogram <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Electrocardiogram <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Holter Monitor <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
MRI/MRA <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Bloodwork (lipids) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Referring Physician Name: _____ **Phone:** _____
Signature: _____ **Billing number:** _____
Referral Date: _____ **Primary Care Provider:** _____

Please fax this form and copies of all investigations to: Stroke Prevention Clinic 519-272-8242
INCOMPLETE OR ILLEGIBLE FORMS MAY RESULT IN DELAYS