

**Stroke Prevention Clinic Referral**

Fax: 613-345-8348 phone 613-345-5645 x 1410


|                  |       |
|------------------|-------|
| Name             | _____ |
| DOB              | _____ |
| Address          | _____ |
| _____            | _____ |
| Family Physician | _____ |
| OHIP             | _____ |
| Phone            | _____ |

Referred by \_\_\_\_\_ (Print)

Source  ED  In Pt unit \_\_\_\_\_

PCP  NP  Specialist \_\_\_\_\_

**\*IF PATIENT PRESENTS WITHIN 48 HRS OF SYMPTOM ONSET, SEND PATIENT TO EMERGENCY DEPARTMENT\***

|   |   |
|---|---|
| <p><b>Reason for Referral:</b> <input type="checkbox"/> TIA/Stroke <input type="checkbox"/> ? TIA/Stroke</p> <p><b>ONSET:</b> _____ (date/time)</p> <p><b>PRESENTATION:</b> <input type="checkbox"/> One Time <input type="checkbox"/> Persistent <input type="checkbox"/> Fluctuating</p> <p><b>DURATION:</b> ____Sec ____Mins ____Hrs ____Days</p> <p><b>MOTOR :</b> Weakness <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg</p> <p><b>SENSORY:</b> Loss <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg</p> <p><b>SPEECH:</b> Disturbance <input type="checkbox"/> Slurred <input type="checkbox"/> Expressive<br/><input type="checkbox"/> Word Finding <input type="checkbox"/> Other _____</p> <p><b>VISUAL:</b> Disturbance <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU <br/><input type="checkbox"/> Visual Field Loss<br/><input type="checkbox"/> Amaurosis Fugas<br/><input type="checkbox"/> Diplopia<br/><input type="checkbox"/> Blurred</p> <p><b>BALANCE:</b> Impairment <input type="checkbox"/> Ataxia <input type="checkbox"/> Sudden Imbalance<br/><input type="checkbox"/> Other _____</p> | <p><b>Risk Factors/Patient History:</b></p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Dyslipidemia</p> <p><input type="checkbox"/> Previous CVA /TIA</p> <p><input type="checkbox"/> Heart Disease _____</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Carotid Stenosis (known)</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Sedentary Lifestyle</p> <p><input type="checkbox"/> Smoking/Vaping</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Drugs _____</p> <p><input type="checkbox"/> Family Hx of heart disease or CVA</p> <p><input type="checkbox"/> Other _____</p> |
|---|---|

**Diagnostic Testing :** Please indicate testing ordered and attach results if not completed at Brockville General Hospital

- CT (head)
- CTA (head and neck)
- ECG
- CBC, Electrolytes, PTT, INR, Creatinine, GFR, Lipid profile, Blood Sugar, HA1C, ALT and Troponin
- MRI
- Holter monitor 48 hrs (if suspected cardio embolic source or stroke mechanism unidentified)
- Echocardiogram (if suspected cardio embolic source or stroke mechanism unidentified)
- Carotid Doppler (if CTA is contraindicated because of CKD or Contrast Dye Allergy)

Please proceed with the minimum testing required listed in BOLD and consult to SPC without delay

 Heart & Stroke Recommendations: visit: [www.strokebestpractices.ca](http://www.strokebestpractices.ca)

**Medications Initiated:** \_\_\_\_\_

**Comments/Consults/ Referrals:** \_\_\_\_\_

**Teaching->** Please review the need to act FAST and CALL 911 with new or worsening symptoms.

Signature \_\_\_\_\_

Date: \_\_\_\_\_