Patient Name:
Date of birth: Age:
Address:

Patient label

BROCKVILLE GENERAL HOSPITAL

Stroke Prevention Clinic
REFERRAL FORM
Fax: 613-345-8348
Phone: 613-345-5645 ex 1410

The following MUST be completed by the Referring Physician or Nurse Practitioner
Please FAX completed form along with ER report (if available), and results to 613-345-8348

Date of most recent TIA/Stroke event: _______________

Clinical Features: (check (✓) all that apply)
- ☐ Unilateral weakness
  - o Face, Arm, Leg (please circle)
  - o Right or Left (please circle)
- ☐ Unilateral sensory loss
  - o Face, Arm, Leg (please circle)
  - o Right or Left (please circle)
- ☐ Speech disturbance ___________________________
- ☐ Visual change _______________________________
- ☐ Other: (describe)______________________________

Duration of Symptoms: (check (✓) the most appropriate)
- ☐ ____Seconds ☐ ___Hours
- ☐ ____Days ☐ ___Minutes
- ☐ Intermittent/Recurring

Risk Factors: (check (✓) all that apply)
- ☐ Atrial Fibrillation
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Previous Stroke or TIA
- ☐ Previous known Carotid Disease
- ☐ Family history: ________________
- ☐ Current Smoker or History of Smoking
- ☐ Alcohol Use Disorder
- ☐ Substance Use Disorder

Please indicate tests that have been completed or pending:
- ☐ **CT head non-contrast**
- ☐ **CT angiogram (head and neck)** *(recommend done same time as CT)*
- ☐ **Carotid Doppler** (if CT angiogram not done)
- ☐ **ECG (12 lead)**
- ☐ **Blood work to include:**
  Lipid profile (fasting not required unless indicated)
  CBC, Electrolytes, Creatinine /eGFR, ALT, INR, PT, PTT
  random glucose or HbA1C
- ☐ **Echocardiogram**
- ☐ **Holter monitor (24-48 h if Atrial Fibrillation suspected)**
- ☐ **Loop monitor (2 weeks if Atrial Fibrillation suspected)**

Treatment initiated: (✓ all that apply)
- ☐ Antiplatelet therapy________________
- ☐ Anticoagulation: ______________________
- ☐ Antihypertensive: _____________________
- ☐ Statin: _________________________________
- ☐ Smoking cessation: ________________
- ☐ Other: _________________________________
- ☐ **Attach list of medications**

Best Practice Recommendations:
***Identification of moderate to high-grade (50-99%) carotid stenosis** on CT angiography typically warrants urgent referral to a vascular surgeon.
***Acute Antiplatelet Therapy Prevents Stroke.**

PLEASE INCLUDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST IN TRIAGING THIS REFERRAL:

Referred by: (Please check (✓))
☐ Family Physician/Nurse Practitioner ☐ ER Physician/Nurse Practitioner ☐ Hospitalist

Printed Name: ____________________________**Signature:**_______________________________ **Date:** _____________

PATIENTS WILL BE CONTACTED PROMPLY FOR AN APPOINTMENT IN THE STROKE PREVENTION CLINIC. PLEASE NOTE THAT COMPLETION OF THE APPROPRIATE IMAGING AND LAB STUDIES IS ESSENTIAL FOR COMPLETE ASESSMENT.

Updated May 2, 2018