

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>Reason for Referral: <input type="checkbox"/> TIA/Stroke <input type="checkbox"/> ? TIA/Stroke</p> <p>ONSET: _____ (date/time)</p> <p>PRESENTATION: <input type="checkbox"/> One Time <input type="checkbox"/> Persistent <input type="checkbox"/> Fluctuating</p> <p>DURATION: ____Sec ____Mins ____Hrs ____Days</p> <p>MOTOR : Weakness <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg</p> <p>SENSORY: Loss <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg</p> <p>SPEECH: Disturbance <input type="checkbox"/> Slurred <input type="checkbox"/> Expressive <input type="checkbox"/> Word Finding <input type="checkbox"/> Other _____</p> <p>VISUAL: Disturbance <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU  <input type="checkbox"/> Visual Field Loss <input type="checkbox"/> Amaurosis Fugas <input type="checkbox"/> Diplopia <input type="checkbox"/> Blurred</p> <p>BALANCE: Impairment <input type="checkbox"/> Ataxia <input type="checkbox"/> Sudden Imbalance <input type="checkbox"/> Other _____</p>	<p>Risk Factors/Patient History:</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>
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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

Medications Initiated: _____

Comments/Consults/ Referrals: _____

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

Signature _____

Date: _____