












# STROKE PREVENTION CLINIC


## PATIENT SUMMARY

**INSERT STROKE  
NETWORK/  
ORGANIZATIONAL  
LOGO**

INFORMATION			
Date of visit		My nurse	
My doctor		Other	

MY DIAGNOSIS			
	Transient Ischemic Attack (TIA)		Ischemic Stroke
	Hemorrhagic Stroke		Other:

WHAT ARE MY STROKE RISK FACTORS? (CHECK THOSE THAT APPLY TO YOU)			
RISK FACTORS I CAN CHANGE		RISK FACTORS I CANNOT CHANGE	
 High blood pressure		 Abdominal obesity	 Atrial fibrillation
 Smoking/vaping		 Inactivity	
 Diet/Unhealthy eating		 High blood cholesterol	
 Uncontrolled diabetes		 Alcohol intake	
 Sleep apnea		 Stress/Mood	

MY PLAN OF CARE	
<b>NEW MEDICATIONS</b>	
Medication Name: Reason:	Medication Name: Reason:
Medication Name: Reason:	Medication Name: Reason:
Medication Name: Reason:	Medication Name: Reason:
 You might be starting new medications. It is important to take them properly. Speak to your doctor, nurse or pharmacist if you have questions about any medications you are taking.	

**TESTS I STILL NEED**

1.	2.
3.	4.

All test results and your clinic visit note will be sent to your Family Doctor.

**APPOINTMENTS THAT HAVE BEEN MADE FOR ME:**

1.	2.
3.	4.



Schedule a visit with your Family Doctor to discuss the results of any tests that were not yet available at the time of your visit at the Stroke Prevention Clinic. Bring this document to your next doctor's appointment and review it with them.

**DRIVING**

	No restrictions on driving
	Do not drive for ____ days Next steps:
	Do not drive – Ministry of Transportation has been notified. Next steps:

**Support Services in my Community | [www.thehealthline.ca](http://www.thehealthline.ca)**  
**Community and Social Services Helpline | Call 2-1-1**  
**For Stroke Information | [www.heartandstroke.ca](http://www.heartandstroke.ca)**












**Stroke and TIA are a medical emergency!**



Learn and recognize and respond immediately to any of these signs of stroke. Call 9-1-1 even if your symptoms go away.

**WHO TO CONTACT WITH QUESTIONS:**

**SITE LOGO:**

MY STROKE RISK FACTORS																		
RISK FACTORS	CURRENT	TARGET	THINGS I CAN CHANGE															
	Today's blood pressure:	<table border="1"> <tr> <td colspan="3">Systolic (mm Hg)</td> </tr> <tr> <td colspan="3">Diastolic (mm Hg)</td> </tr> <tr> <td>Below 140</td> <td>Below 130</td> <td>Below 135</td> </tr> <tr> <td>Below 90</td> <td>Below 80</td> <td>Below 85</td> </tr> <tr> <td>CLINIC</td> <td>DIABETES</td> <td>AT HOME</td> </tr> </table>	Systolic (mm Hg)			Diastolic (mm Hg)			Below 140	Below 130	Below 135	Below 90	Below 80	Below 85	CLINIC	DIABETES	AT HOME	
Systolic (mm Hg)																		
Diastolic (mm Hg)																		
Below 140	Below 130	Below 135																
Below 90	Below 80	Below 85																
CLINIC	DIABETES	AT HOME																
	Cholesterol: LDL: Triglycerides: Non HDL-C: HDL:	Total: <5.2 LDL: < Triglycerides: <1.7 Non HDL-C: <2.6 HDL: >1.0 (men) >1.3 (women)																
	HbA1C: Fasting blood sugar:	For most people: HbA1C: 7% or less Fasting blood sugar: 4-7mmol/L																
	<input type="checkbox"/> Smoking <input type="checkbox"/> Cutting back <input type="checkbox"/> Non-smoker	Smoke and tobacco free																
	Waist circumference:	Men: <102 cm (40") Women: <88 cm (35")																
	Meals/day: Fruits & veggies/day:	3 meals per day 7 servings of fruits & vegetables/day																
	Exercise: Minutes/day: Days/week:	150 minutes moderate to vigorous activity per week in periods of 10 minutes or more																
	Drinks/week:	Women: <10 drinks a week to a maximum of 2 per day. Men: <15 drinks a week to a maximum of 3 per day. In some cases NO alcohol.																
	Sleep ____ hours/night Sleep apnea: Yes or No	Sleep 6 to 8 hours/night																
	<input type="checkbox"/> Feeling stress <input type="checkbox"/> Feeling depressed	Reduce activities that cause stress																
	Atrial fibrillation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication prescribed:																