Timmins and District Hospital
Secondary Stroke Prevention Clinic
Referral Form

The following information **MUST** be completed (incomplete forms will be returned for completion):
FAX completed form to: **705-360-6097** **Telephone: 705-360-6098**

Demographic Label

Patient / Caregiver best contact number:
_____

Patient age: _____yrs Gender: Male ☐ Female ☐
Reason for referral: TIA ☐ Stroke ☐ Other ☐
Most recent TIA/Stroke event:

Date: _____ Time: _____

Clinical features (check (√) all that apply):

☐ Hemibody weakness face ☐ arm ☐ leg ☐ (L or R)
☐ Hemibody numbness face ☐ arm ☐ leg ☐ (L or R)
☐ Speech difficulty (slurred or expressive/word finding difficulty
☐ Clear monocular or hemifield vision loss (temporary or persistent)
☐ Other symptoms: _____
_____
_____
_____
_____
_____
_____
_____
_____

Duration of symptoms (check (√) all that apply):

☐ _____ seconds
☐ _____ minutes or ☐ greater than 10 min
☐ Single episode or ☐ recurrent/fluctuating

Tests completed or pending and results attached for:

CT	☐	Complete ☐	
MRI/MRA (if indicated)	☐	Complete ☐	Pending ☐
CTA*	☐	Complete ☐	Pending ☐
Carotid U/S	☐	Complete ☐	Pending ☐

***CTA should be completed within less than 24 hrs after presentation for high-risk patients (possible carotid territory event, e.g. hemibody weakness or speech symptoms)**

ECG	☐	Complete ☐	Pending ☐
LOOP Monitor (consider M cards)	☐	Complete ☐	Pending ☐
Relevant Blood work (including HbA1c/Lipid Profile)	☐	Complete ☐	Pending ☐

Treatment initiated (check (√) all that apply):

☐ Antiplatelet therapy: _____
☐ Anticoagulant: _____
☐ ACE or ARB: _____
☐ Statin: _____
☐ Other:_____
Other comments: _____
_____
_____

Risk Factors (check (√) all that apply):

☐ Hypertension
☐ History of atrial fibrillation
☐ Diabetes
☐ Hyperlipidemia
☐ Ischemic heart disease; previous CABG year: _____
☐ Previous Stroke or TIA
☐ Previous known carotid disease: ☐L, ☐R; __% stenosis
☐ Previous carotid endarterectomy/stent year: _____
☐ History of sleep apnea
☐ Current smoker ☐ Ex-smoker: ____pack ____yrs

Referring practitioner's name (print clearly): _____
Signature: _____ OHIP billing/provider number: _____
Referral date: _____
Referred by: ☐ ER Physician ☐ Family Physician ☐ Nurse Practitioner ☐ Specialist physician _____
Location of referral source: ☐ Emergency Department ☐ Physician's office/clinic ☐ Inpatient

Key Best Practices:

- Acute antiplatelet therapy prevents stroke
- ACE/ARB and statin to be started as soon as possible
- Identification of moderate to high grade (50-99%) stenosis on carotid ultrasound typically warrants urgent referral to Vascular surgeon on call for assessment for possible carotid endarterectomy
- Patients with suspected TIA/minor (ischemic) stroke and known atrial fibrillation should be adequately anticoagulated(if no absolute contraindication)

For further recommendations visit: ***http://www.strokebestpractices.ca/index.php/prevention-of-stroke/***