# STROKE PREVENTION CLINIC REFERRAL FORM – GBHS

## Owen Sound 519-376 -2121 Ext 2922

**Date of Event:** _____ **Duration of Symptoms:** _____ **(min/hrs)**

| **Signs/Symptoms:** | | | **Side (R/L)** | **Duration (mins)** |
|---|---|---|---|---|
| Unilateral motor deficits | Yes | No | _____ | _____ |
| Unilateral numbness/tingling | Yes | No | _____ | _____ |
| Aphasia | Yes | No | _____ | _____ |
| Dysarthria | Yes | No | _____ | _____ |
| Amaurosis Fugax | Yes | No | _____ | _____ |
| Vertigo* | Yes | No | _____ | _____ |
| Headache | Yes | No | _____ | _____ |

Other _____

*Must be accompanied by one other symptom (e.g. dysarthria, diplopia, ataxia)

**Patient Legal Name :** ☐ **M** ☐ **F**

_____

Address: _____

City: _____

Postal Code: _____

Phone # _____

Alternate Phone # _____

D.O.B: _____/_____/_____

(YYYY/MM/DD)

Health Card #: _____

Version Code: _____ Exp.: _____

**Risk Factors:**

☐ Atherosclerosis
☐ Hypertension
☐ Ischemic heart disease
☐ Hyperlipidemia
☐ Depression
☐ Previous stroke/ tia
☐ Atrial Fibrillation
☐ Diabetes
☐ Sleep apnea
☐ Tobacco use
☐ Obesity (BMI>25)
☐ Family Hx stroke

**SPC Follow Up Only**

**Inpatient Unit Ext: _____**

**F/U ☐ DR YOUNG ☐ DR DAFE ☐ SPC**

**FAX TO SPC CLINIC (519-378-1444)**

**☐ MTO NOTIFIED ☐ ATTACH COPY OF FAXED FORM**

**☐ PATIENT AWARE OF MTO NOTIFICATION**

### ☐ HIGHEST/HIGHER RISK (please check off tests to be ordered)

If patient **presents within 48 hours** from symptom onset or more than 48 hours with transient, persistent or fluctuating motor or speech symptoms, or symptoms such as hemisensory loss, acute monocular visual loss, binocular diplopia:

☐ CTA of Head and Neck **OR** ☐ Carotid Doppler **AND** Head CT (URGENT)
☒ ECG (URGENT)

*****Initiate Antiplatelet therapy if no blood on CT scan**

### ☐ INCREASED RISK (please check off tests to be ordered)

If patient **presents between 48 hours and 2 weeks** from symptom onset with transient, persistent or fluctuating motor or speech symptoms, or symptoms such as hemisensory sensory loss, acute monocular visual loss, binocular diplopia

☐ CTA of Head and Neck **OR** ☐ Carotid Doppler **AND** Head CT (within 24 hours)
☒ ECG (within 24 hours)

*****Initiate Antiplatelet therapy if no blood on CT scan**

### ☐ LOWER RISK (please check off tests to be ordered)

If patient **presents after 2 weeks** with isolated sensory symptoms may be considered less urgent if not accompanied by high risk symptoms

☐ CTA of Head and Neck **OR** ☐ Carotid Doppler **AND** Head CT (within 1 week)
☒ ECG (within 1 week)

*****Initiate Antiplatelet therapy if no blood on CT scan**

### Laboratory Investigations (Please ensure following tests have been ordered at the time of referral)

| | | | | |
|---|---|---|---|---|
| ☑ CBC | ☑ LYTES | ☑ CR | ☑ GFR | ☑ ALT |
| ☑ Fasting Blood Sugar | ☑ Hgb A1C | ☑ HDL | ☑ LDL | |
| ☑ Cholesterol | ☑ aPTT | ☑ TRIGLYCERIDES | ☑ INR | |

Authorized Provider Signature: _____

Print: _____

Authorized Provider Phone #: _____

Date: _____

**FAX COMPLETED FORM TO SCHEDULING: 519-376-3952**

***INCLUDE SUPPORTING DOCUMENTATION**

**(i.e. ER Record, Lab work, DI tests, etc.)**

**SPC will complete electro diagnostic testing once seen in clinic**

**M-230 Revised October 2019**

* P H Y 0 0 2 *