SOUTHLAKE
REGIONAL HEALTH CENTRE

Stroke Prevention Clinic
596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Stroke Prevention Clinic Referral Form

Please fax to 905-853-2222

Patient Name: *(print first, last)*

Patient Preferred Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(print first, last)*

Additional Copies to:

Referral Source: ❑ ED ❑ In-Patient ❑ Out-Patient ❑ MD office ❑ Physician ❑ Nurse Practitioner
❑ GEM Nurse ❑ Discharge Planner ❑ Other Clinician **Name:** *(print first, last)* _____

REASON FOR REFERRAL: *check appropriate box (✓)*

1. ❑ Signs and Symptoms of TIA /Stroke *(please circle ABCD² triage score)*

A	❑ Age greater than 60 years old	1 Point
B	❑ SBP above 140 mmHg and/or DBP above 90 mmHg	1 Point
C	❑ Clinical symptoms involve weakness or speech deficit	2 Points
D	❑ Duration 1 hour or more	2 Points
	❑ or between 10-59 minutes	1 Point
D	❑ Diabetes	1 Point

Additional Concerns: ❑ Headache ❑ Atrial fibrillation ❑ Disorientation/memory loss ❑ Previous TIA/Stroke

Other: _____

2. ❑ Follow-up Stroke Event/Hospital Admission for Secondary Stroke Prevention

3. ❑ Risk Reduction/Lifestyle Modification for Stroke Prevention

Attach all relevant document(s) – Emergency Record or Discharge Summary. ❑ ECG ❑ CT Scan

Fax the referral to (905) 853-2222. Questions or consultation can be directed to the Nurse Practitioner at ext 6479.
For clinic administrative assistance, call extension 6480, Mon-Fri 0800-1130.

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

❑ Emergent (6-7 points) ❑ Urgent (4-5 points) ❑ Non-Urgent (0- 3 points)

Date referral received: dd / mm / yy | **APPOINTMENT – Date:** dd / mm / yy **Time:** _____