SOUTHLAKE
REGIONAL HEALTH CENTRE

Stroke Prevention Clinic
596 Davis Drive
Newmarket, ON L3Y 2P9
Tel: (905) 895-4521 ext. 5358
Fax: (905) 853-2299

AFFIX PATIENT LABEL HERE

Patient Name: *(Print first, last)*_____

DOB: dd / mm / yy MRN: _____ HCN + version code: _____

Telephone No.: _____ Alternative contact: _____

Interpreter Required ❑ _____ (language)

Stroke/TIA Clinic Referral Form

The mandate of the SPC is to provide timely access to patients at high risk for stroke. Please consider referral to cardiology for isolated syncope, ENT for isolated vertigo, ophthalmology for vague visual symptoms and Geriatrics for progressive cognitive impairment.

REFERRAL SOURCE: ❑ ED ❑ In-Patient ❑ Out-Patient/MD office **Incomplete/illegible referrals may be returned for clarification*

TIME FROM SYMPTOM ONSET *(please check)*	CLINICAL FEATURES *(please check)*	RISK CATEGORY
❑ Up to 24 hours (SEND TO EMERGE)		
❑ 24 hours to 48 hours	Any listed below *(please check all that apply)*	Very High
❑ 48 hours to 2 weeks	❑ Unilateral weakness ❑ Face ❑ Arm ❑ Leg ❑ Right ❑ Left ❑ Speech Disturbance	High
	❑ Unilateral sensory disturbance ❑ Monocular/ hemifield Vision Loss ❑ Right ❑ Left ❑ Symptoms suggestive of posterior circulation event (diplopia, dysarthria, dysphagia, ataxia)	Moderate
❑ Greater than 2 weeks	Any of above *(please check all that apply)*	Lower

Duration of symptoms
- ❑ < 60 min
- ❑ > 60 min
- ❑ < 24 hours
- ❑ Persistent

Medications
- ❑ Dual Antiplatelet Therapy
- ❑ Single Antiplatelet Therapy
- ❑ Statin
- ❑ Oral Anticoagulant

***BRING LIST OF CURRENT MEDICATIONS**

Risk Factors
- ❑ Hypertension
- ❑ Diabetes a1c _____
- ❑ Dyslipidemia LDL _____
- ❑ A.Fib OAC _____
- ❑ CAD
- ❑ Smoking

Investigations

Please send all pertinent results and/or requisitions

Completed	Pending	
❑	❑	CT
❑	❑	MRI
❑	❑	CTA
❑	❑	Carotid Doppler
❑	❑	ECHO
❑	❑	ECG
❑	❑	Holter Monitor

❑ Referral to vascular surgery for carotid stenosis > 50% or moderate/severe stenosis (symptomatic).

Referring Provider *(print name)*: _____ Billing #: _____

Referring Provider *(signature)*: _____ Date: dd / mm / yy

Phone Number: _____ Fax Number: _____ Primary Care Provider Name: _____