STROKE PREVENTION CLINIC (SPC)
REFERRAL FORM

Addressograph

Phone: 1-613-732-3675 Ext. 6640
1-855-293-7838

FAX: 1-613-732-6350
1-855-293-7839

Referral Source: ☐ Emergency Department ☐ Physician's Office ☐ Specialist ☐ Other

Primary Care Physician: ___________________________

Reason for Consultation:

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Signs and Symptoms: See the *TIA Management in the Emergency Department Algorithm*

Unilateral motor deficit (arm / leg / face)	Yes	No	**Right or Left** _________
Unilateral numbness or tingling (arm / leg / face)	Yes	No	**Right or Left** _________
Speech Disturbance	Yes	No	
Aphasia	Yes	No	
Amaurosis fugax	Yes	No	**Right or Left** _________

Other:____________________________

Symptoms Onset:____

Symptom duration: ☐ Less than 10 minutes ☐ 10-59 minutes ☐ Greater than 60 minutes

Risk Factors (Current or Past History):

☐ Hypertension ☐ Smoking

☐ PVD ☐ Dyslipidemia

☐ CAD ☐ Previous Stroke/TIA

☐ Diabetes ☐ Sleep Apnea

☐ Atrial Fibrillation ☐ Carotid Stenosis

Medications:
(Please attach current medications)

Treatment Initiated:
☐ Antiplatelet ☐ Anticoagulant ☐ Antihypertensive ☐ Statin ☐ Other ___________________________

Completed Tests and Investigations (please attach all completed reports)**:**
☐ CT ☐ ECG ☐ MRI ☐ Echocardiogram ☐ CTA ☐ Holter

☐ Non-Fasting Random Glucose ________ ☐ Non-Fasting Lipid Profile ______ ☐ Electrolytes _______
☐ CBC _______ ☐ INR/PTT _______ ☐ Urea _______ ☐ Creatinine ________

Referring Physician: _______________________________ **Signature:** _____________________________________

Date (yyyy/mm/dd): ___________________________