Toronto Stroke Networks
North & East GTA

Sunnybrook
HEALTH SCIENCES CENTRE

# North and East GTA Stroke Network Secondary Prevention Clinic

Name: _____

Address: _____

_____

Tel. #: _____

OHIP #: _____

DOB: _____

Alternate Contact (name/Tel): _____

**Please fax this form and copies of all relevant investigations and blood work to: (416) 480-5753**
Our office will contact patient directly with appointment details
Telephone: 416-480-4473 or 416-480-4866

**Referring Physician** (PLEASE PRINT CLEARLY)
_____

Clinic: _____

Office Phone Number: _____

Office Fax Number: _____

OHIP Billing Number: _____

Physician's signature: _____

**Reason for referral**:

- ☐ TIA** (please indicate date and duration of event below)
- ☐ Recent stroke (Date:_____)
- ☐ Past stroke (Year:_____)
- ☐ Asymptomatic carotid disease
- ☐ Abnormal brain imaging
- ☐ Primary prevention in high risk patient
- ☐ Stroke Sub-Speciality (provide details in comments below)
- ☐ Other: _____

****Date of stroke :** _____
**Type of stroke**: □ Ischemic □ Hemorrhagic
**Brain region involved**: -
_____

****Duration of Symptoms**:
□Seconds □ Minutes: _____
□ Hours:_____ □ Days: _____
□Ongoing
**Presenting Signs**: (PLEASE CHECK ALL THAT APPLY)
□ Speech Disturbance
□ Motor weakness (R / L) Face Arm Leg
□ Visual Disturbance
□ Balance Problem / dizziness
□ Sensory changes (R / L) Face Arm Leg
□ Other: _____

Fax Reports for the following stroke investigations and **attach to the referral:**
□ CT head
□ CTA
□ MRI head
□ Carotid dopplers
□ Echocardiogram
□ ECG
□ Holter

**Additional comments:**

**Vascular Risk factors:**
□ Hypertension
□ Diabetes
□ CAD
□ Previous TIA/Stroke
□ Sleep apnea
□ Other: _____
□ Smoking
□ Dyslipidemia
□ Atrial Fibrillation
□ Family Hx Stroke/CAD

**Treatments Initiated:**
**Antiplatelet:**
□ ASA
□ Clopidogrel
□ Aggrenox
□Other: _____
□ **Statin**

**Anticoagulant:**
□ Warfarin
□ Apixaban
□ Dabigatran
□ Rivaroxaban
□ Other: _____