

## TIA and Stroke Prevention Referral

 **Urgent (See criteria below)**  
 **Standard**  
 Fax: 416-864-5712  
 Tel: 416-864-5056

<b>Patient Information (or apply patient demographics sticker)</b> Last Name _____ First Name _____ DOB (dd/mmm/yyyy) _____ Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Health card number _____ Version Code _____ Address _____ Phone number _____ Alternative number _____	Alternative contact person (Name/Phone) _____ Suitable for virtual visit <input type="checkbox"/> yes <input type="checkbox"/> no Email _____ Consent to email contact <input type="checkbox"/> yes <input type="checkbox"/> no Interpreter required <input type="checkbox"/> yes <input type="checkbox"/> no <i>* If an interpreter is required, please ask patient to bring their own interpreter to avoid any delay in scheduling.</i>
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<b>Referring Physician Information</b> Name (please print): _____ Billing Number: _____ Family Physician: _____	<b>Reason for referral:</b> <input type="checkbox"/> TIA <input type="checkbox"/> Stroke <input type="checkbox"/> Carotid disease <input type="checkbox"/> Intracerebral hemorrhage <input type="checkbox"/> Other _____
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<b>Antithrombotic Therapy (check all that apply)</b> <input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel (Plavix) <input type="checkbox"/> Dipyridamole-ASA (Aggrenox) <input type="checkbox"/> Warfarin (Coumadin) <input type="checkbox"/> DOAC _____	<b>Stroke Risk Factors (check all that apply)</b> <input type="checkbox"/> Previous stroke/TIA <input type="checkbox"/> Carotid disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Smoking <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Coronary artery disease
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**Description of Event**

Date(dd/mmm/yyyy) \_\_\_\_\_ Duration  minutes  hours  days Did all symptoms resolve?  yes  no

Symptom (Please check all that apply and circle the side if applicable)

<input type="checkbox"/> Speech disturbance	<input type="checkbox"/> Imbalance/Vertigo	<input type="checkbox"/> Headache
<input type="checkbox"/> Motor weakness ( R / L ) <input type="checkbox"/> face <input type="checkbox"/> arm <input type="checkbox"/> leg	<input type="checkbox"/> Sensory disturbance ( R / L ) <input type="checkbox"/> face <input type="checkbox"/> arm <input type="checkbox"/> leg	<input type="checkbox"/> Visual disturbance ( R / L ) <input type="checkbox"/> monocular <input type="checkbox"/> field loss <input type="checkbox"/> diplopia

Additional information

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**Criteria for Urgent Referrals (<72 hour turnaround time, 24-48 hours during week)**

- Patient with acute onset neurological symptoms with **complete recovery** (TIA) or **very mild residual deficits** (able to ambulate, care for themselves at home)
- Complete ALL of the following investigations**
  - CT and CTA of the head (arch to vertex) – **MUST BE COMPLETED (usually in the context of ED visit)**  
RESULT: \_\_\_\_\_
  - ECG (**fax actual ECG**) RESULT: \_\_\_\_\_
  - Lipids, glucose, HbA1C
  - Basic bloodwork: CBC, electrolytes, liver enzymes, creatinine
- Blood pressure in ED: \_\_\_\_\_

**Please fax completed referral and ED face sheet to 416-864-5712. Patient will be contacted within 72 hours. Please provide patient with the Patient Information Sheet (see Page 2). Unfortunately, we cannot accommodate urgent referrals without CTA/ECG at the moment. Incomplete referrals will be triaged as next available appointment.**

*For all patients, please attach the relevant clinical notes, list of medications and investigations (bloodwork, cardiac testing and neuroimaging) to the referral.*

**Signature** \_\_\_\_\_ **Date (mm/dd/yyyy)** \_\_\_\_\_

**Internal Use:** Triaged to Dr. \_\_\_\_\_ Urgency: \_\_\_\_\_ Date: \_\_\_\_\_

# St Michael's Hospital Rapid TIA and Minor Stroke Clinic

## Patient Information Sheet

- You have been referred to the Rapid TIA and Minor Stroke Clinic.
  
- The Stroke Prevention Clinic will review the referral information and offer you either a virtual (by telephone or video) or in-person consultation by a stroke neurologist.
  
- You will be contacted within 24-48 hours (during the week) or on Monday if you present on a Friday, Saturday or Sunday.
  
- If you do not hear about an appointment within that time frame, please call the Stroke Prevention Clinic at: 416-864- 5056.
  
- If you experience sudden onset weakness, numbness/tingling, speech difficulties, vision changes or any other concerning symptoms, please seek urgent medical attention and call 9-1-1.

**Internal Use:** *Triaged to Dr.* \_\_\_\_\_ *Urgency:* \_\_\_\_\_ *Date:* \_\_\_\_\_