Secondary Stroke Prevention Clinic

Referral Form

Fax to: 905-357-9230

*** ATTENTION ***

All referrals must have referring physician's name CLEARLY PRINTED.
Please attach any relevant test results to this referral (e.g. Carotid imaging, CT/MRI, labs)

Date of TIA/Stroke event:_____

Symptoms: (Check all that apply)

__ Unilateral Weakness
__ Speech Disturbance
__ Visual Disturbance
__ Other _____

Symptom Duration:

__ Seconds
__ Minutes
__ Hours
__ Days
__ Intermittent/recurring

Patient Demographic Label

_____

**** Patient's Phone Number ****

Investigations Ordered/Completed:

__ CT head or MRI head
__ Carotid Doppler u/s
__ ECG
__ Holter monitor
__ Blood work

Treatment Initiated:

__ Antiplatelet therapy: _____
__ Anticoagulant: _____
__ ACE or ARB: _____
__ Statin: _____
__ Other: _____

Risk Factors/Relevant Health History:

__ Hypertension
__ Dyslipidemia
__ Diabetes
__ Atrial Fibrillation
__ Ischemic Heart Disease
__ Previous TIA/Stroke
__ Previous Known Carotid Disease
__ Smoker
__ Sleep Apnea

Referring Physician (Please Print):	**Signature:**	**Date:**

Revised February 3 2015