

# STROKE PREVENTION CLINIC PATIENT REFERRAL

**Clinic Located at the Hamilton General Hospital Site**  
237 Barton St. East 905-521-2100 ext 44713

**Fax completed referral form to: 905-577-8044**

The purpose of the secondary Stroke Prevention Clinic is to provide quick access to consultation and diagnostic testing for patients identified to be at risk for stroke.

Patient's Last Name		First Name	
Address			
City	Province	Postal Code	
ID Number	HIN		
Patient's Birthdate (yyyy/mm/dd)	Age	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Home Phone Number	Work / Alternate Phone Number		

**Persons presenting with recent stroke symptoms and/or requiring emergency neurological consultation should be directed to the nearest Emergency Department.  
The following form MUST be completed by the Referring Physician or Nurse Practitioner.**

<p><b>Patient/caregiver <u>BEST</u> contact number:</b> _____</p> <p><b>BP at time of event:</b> _____</p> <p><b>Reason for referral:</b> <input type="checkbox"/> TIA <input type="checkbox"/> Stroke <input type="checkbox"/> Carotid Stenosis <input type="checkbox"/> Other: _____</p> <p><b>Date of most recent TIA / Stroke event:</b> _____ (yyyy/mm/dd)</p> <p><b>Clinical Features:</b> (Check (✓) all that apply)</p> <p><input type="checkbox"/> Unilateral weakness: <input type="checkbox"/> face <input type="checkbox"/> arm <input type="checkbox"/> leg (<input type="checkbox"/> L <input type="checkbox"/> R)</p> <p><input type="checkbox"/> Unilateral sensory loss: <input type="checkbox"/> face <input type="checkbox"/> arm <input type="checkbox"/> leg (<input type="checkbox"/> L <input type="checkbox"/> R)</p> <p><input type="checkbox"/> Speech disturbance (slurred or expressive/word finding difficulty)</p> <p><input type="checkbox"/> Amaurosis fugax</p> <p><input type="checkbox"/> Hemianopsia</p> <p><input type="checkbox"/> Other: _____</p> <p><b>Duration of Symptoms:</b> (Check (✓) most appropriate)</p> <p><input type="checkbox"/> ___ Seconds</p> <p><input type="checkbox"/> ___ Minutes <b>OR</b> <input type="checkbox"/> greater than 10 min.</p> <p><input type="checkbox"/> ___ Hours</p> <p><input type="checkbox"/> ___ Days</p> <p><b>Frequency of Symptoms:</b> <input type="checkbox"/> Single episode <input type="checkbox"/> Recurring / Fluctuating</p> <p><b>Risk Factors:</b> (Check (✓) all that apply)</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Previous stroke or TIA</p> <p><input type="checkbox"/> History of atrial fibrillation <input type="checkbox"/> Previous known carotid disease</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Current or past smoker</p> <p><input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> History of sleep apnea</p> <p><input type="checkbox"/> Ischemic Heart Disease</p>	<p><b>Tests ordered or results attached for:*</b></p> <p><input type="checkbox"/> CT head (or MRI) _____</p> <p><input type="checkbox"/> Carotid imaging _____</p> <p><input type="checkbox"/> ECG _____</p> <p><input type="checkbox"/> Bloodwork: including lipid panel and HA1C</p> <p>* Head imaging should be performed in the ER since abnormalities may lead to admission.</p> <p>* For referrals from <b>primary care providers</b>, defer ordering tests and refer directly to the Stroke Prevention Clinic.</p> <p><b>Treatment initiated:</b> Check (✓) all that apply</p> <p><input type="checkbox"/> Antiplatelet therapy: _____</p> <p><input type="checkbox"/> Anticoagulant: _____</p> <p><input type="checkbox"/> Other: _____</p> <hr/> <p style="text-align: center;"><b>Key Best Practices</b></p> <p style="text-align: center;"><b>**Head imaging required prior to initiating antithrombotic therapy**</b></p> <p><b>Antiplatelet Therapy:</b></p> <ul style="list-style-type: none"> <li>patients with ischemic stroke or TIA should be prescribed antiplatelet therapy unless there is an indication for anticoagulation</li> </ul> <p><b>Anticoagulation:</b></p> <ul style="list-style-type: none"> <li>patients with ischemic stroke or TIA and atrial fibrillation should receive oral anticoagulation as soon as it is thought to be safe for the patient</li> </ul> <p><b>Carotid Stenosis:</b></p> <ul style="list-style-type: none"> <li>identification of a moderate to high-grade (50-99%) symptomatic stenosis on carotid ultrasound typically warrants urgent referral to the Stroke Prevention Clinic or the Neurologist on call, for assessment of possible carotid intervention</li> </ul>
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**Referred by:** \_\_\_\_\_ (Printed Name) \_\_\_\_\_ (Signature and Designation) \_\_\_\_\_ (Billing Number) \_\_\_\_\_ Date (yyyy/mm/dd)

Family Physician  Nurse Practitioner  ER Physician  Specialist \_\_\_\_\_

**Fax the following items to the Stroke Prevention Clinic:** ER record, ECG, test results and bloodwork if available  
**Do not delay referring patient to the Stroke Prevention Clinic if tests are not done or results are not available.**

