SHN
SCARBOROUGH HEALTH NETWORK

STROKE PREVENTION CLINIC REFERRAL FORM

300000

SHN – Birchmount Hospital Unit 4B
Phone: 416-495-2558
Fax: 416-495-2581

Date of Referral: *day/month/year* _____

Source of Referral: _____

ED: *specify hospital* _____ ***NOTE:*** **Must have CT and CTA or CT and Carotid Doppler completed**

Reason for Referral

❒ **TIA** ❒ **Recent Stroke: Ischemic** **Date of Recent TIA/Stroke** _____

❒ **Other:** _____

Symptom duration _____ ❒ minutes ❒ hours ❒ days **Side of symptoms** ❒ Right ❒ Left ❒ Bilateral

Motor:
❒ Face ❒ Arm ❒ Leg

Sensory:
❒ Face ❒ Arm ❒ Leg

Speech
❒ Dysarthria
❒ Aphasia

Visual
❒ Monocular
❒ Field Loss
❒ Diplopia

Other symptoms or comments relevant to referral: _____

Risk Factors:

❒ Hypertension ❒ DM ❒ Dyslipidemia ❒ CAD ❒ A fib ❒ Smoking ❒ Sleep Apnea

❒ Other: _____

Medications:

Antiplatelet: ❒ ASA ❒ Clopidogrel ❒ Aggrenox ❒ Other _____

Anticoagulant: ❒ Warfarin ❒ Apixaban ❒ Dabigatran ❒ Rivaroxaban ❒ Other _____

❒ Statin

Investigations already completed (Please indicate any concerning findings. Send reports of all previous investigations. The patient must obtain CD/DVDs of any imaging done outside of SHN)

❒ CT ❒ CTA ❒ MRI ❒ MRA ❒ Angiogram ❒ Carotid Doppler ❒ Echo ❒ Holter ❒ Other _____

Significant results: _____

Interpreter required? ❒ No ❒ Yes specify language _____

Best Contact Person – Phone Number & Name _____

Referring Physician: _____ **OHIP Billing Number:** _____ **Signature** _____

Please note, the Stroke Prevention Clinic will contact the patient with an appointment date and time

Distribution: Chart Copy