Brockville General Hospital

Stroke Prevention Clinic Referral

Fax: 613-345-8348 phone 613-345-5645 x 51257

Patient Name_____
DOB_____
Address_____
_____
_____
Phone Number _____
Patient OHIP #/VC_____
Family Physician Name_____

Referred by _____ (Print)

Source ☐ **ED** ☐ **In Pt unit**_____
☐ **PCP** ☐ **NP** ☐ **Specialist**_____

IF PATIENT PRESENTS WITHIN 48 HRS OF SYMPTOM ONSET, SEND PATIENT TO EMERGENCY DEPARTMENT

Reason for Referral: ☐TIA/Stroke ☐? TIA/Stroke

ONSET:_____ (date/time)

PRESENTATION: ☐ One Time ☐ Persistent ☐Fluctuating

DURATION: ____Sec____Mins____Hrs_____Days

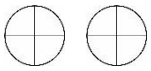
MOTOR : Weakness ☐Right ☐Left ☐Face ☐Arm ☐Leg

SENSORY: Loss ☐Right ☐Left ☐Face ☐Arm ☐Leg

SPEECH: Disturbance ☐Slurred ☐Expressive
☐Word Finding ☐Other_____

VISUAL: Disturbance ☐OD ☐OS ☐OU

OD OS



☐Visual Field Loss
☐Amaurosis Fugas
☐Diplopia
☐Blurred

BALANCE: Impairment ☐Ataxia ☐Sudden Imbalance
☐Other_____

Risk Factors/Patient History:

☐Hypertension
☐Diabetes_____
☐Dyslipidemia
☐Previous CVA /TIA
☐Heart Disease_____
☐Atrial Fibrillation
☐Carotid Stenosis (known)
☐Sleep Apnea
☐Obesity
☐Stress
☐Sedentary Lifestyle
☐Smoking/Vaping
☐Alcohol
☐Drugs_____
☐Family Hx of heart disease or CVA
☐Other_____

Diagnostic Testing : Please indicate testing ordered and attach results if not completed at Brockville General Hospital

☐CT (head)
☐CTA (head and neck)
☐ECG
☐CBC, Electrolytes, PTT, INR, Creatinine, GFR, Lipid profile, Blood Sugar, HA1C, ALT and Troponin
☐MRI
☐Holter monitor 48 hrs (if suspected cardio embolic source or stroke mechanism unidentified)
☐Echocardiogram (if suspected cardio embolic source or stroke mechanism unidentified)
☐Carotid Doppler (if CTA is contraindicated because of CKD or Contrast Dye Allergy)

Please proceed with the minimum testing required listed in BOLD and consult to SPC without delay

Heart & Stroke Recommendations: visit: www.strokebestpractices.ca

Medications Initiated:_____

Comments/Consults/ Referrals: _____

Teaching-> Please review the need to **act FAST** and **CALL 911** with new or worsening symptoms.

Signature_____ **Date**: _____

March 2022