Brockville General Hospital

# STROKE PREVENTION CLINIC REFERRAL

As of September 2023

Name______________________________________
DOB_______________________________________
Address____________________________________
__________________________________________
__________________________________________
Family Physician_____________________________
OHIP _____________________________________
Phone______________________________________

***NEW*** Fax: 613-345-8308 Phone: 613-345-5645 x51257

**REFERRED BY:** ______________________ (Print)

**SOURCE:** ☐ **ED** ☐ **Inpatient Unit**_____________ ☐ **PCP** ☐ **NP** ☐ **Specialist**_______________

***IF PATIENT PRESENTS WITHIN 48 HOURS OF SYMPTOM ONSET, SEND PATIENT TO EMERGENCY DEPT***

**REASON FOR REFERRAL:** ☐ TIA/Stroke ☐ ?TIA/Stroke

**ONSET:** ______________________________ (date/time)

**PRESENTATION:** ☐ One Time ☐ Persistent ☐ Fluctuating

**DURATION:** ____Sec____Mins____Hours_____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

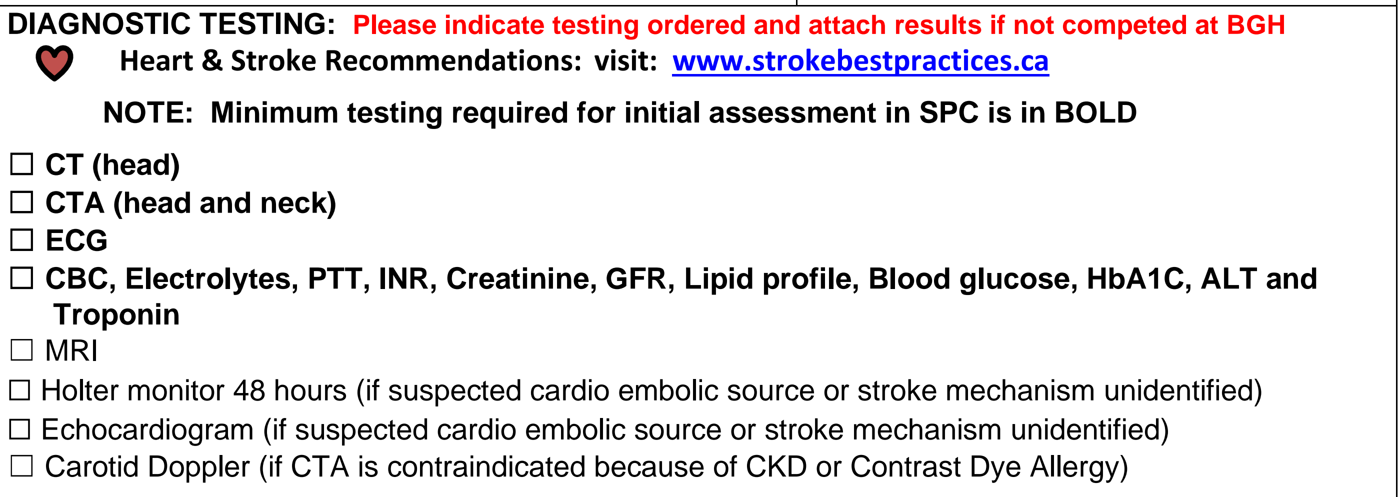
OD OS

☐ 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
☐ Smoker/Vaping
☐ Alcohol
☐ Drugs____________________
☐ Family History of heart disease or CVA
☐ Other____________________



**DIAGNOSTIC TESTING:** **Please indicate testing ordered and attach results if not competed at BGH**

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

**NOTE: Minimum testing required for initial assessment in SPC is in BOLD**

☐ **CT (head)**
☐ **CTA (head and neck)**
☐ **ECG**
☐ **CBC, Electrolytes, PTT, INR, Creatinine, GFR, Lipid profile, Blood glucose, HbA1C, ALT and Troponin**
☐ MRI
☐ Holter monitor 48 hours (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)

**Medications Initiated:** ________________________________________________

**Comments/Consults/Referrals:** __________________________________________

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

**Signature**_________________________________ **Date**: ________________________