HURON PERTH HEALTHCARE ALLIANCE

46 General Hospital Drive
Stratford, ON N5A 2Y6
519-272-8210 ext. 2299

Patient Name: _____

Address: _____

DOB: _____ **Age:** _____

Health Card #: _____

Telephone: _____

STROKE PREVENTION CLINIC REFERRAL FORM

Date of Event (TIA or MINOR STROKE): _____ **Alternate contact:** _____
DD / MM / YYYY

Signs/Symptoms:		**Side (R/L)**	**Duration (mins)**
Unilateral motor deficit(s)	☐Yes ☐No	_____	_____
Unilateral numbness/tingling	☐Yes ☐No	_____	_____
Aphasia	☐Yes ☐No		_____
Dysarthria	☐Yes ☐No		_____
Amaurosis Fugax	☐Yes ☐No	_____	_____
Hemianopia	☐Yes ☐No	_____	_____
Vertigo*	☐Yes ☐No		_____
Headache	☐Yes ☐No	_____	_____

*Must be accompanied by one other symptom (e.g., dysarthria, diplopia, ataxia)

Risk Factors:
- ☐ Atherosclerosis
- ☐ Hypertension
- ☐ Ischemic Heart Disease
- ☐ Hyperlipidemia
- ☐ Atrial Fibrillation
- ☐ Diabetes
- ☐ Previous Stroke or TIA
- ☐ Tobacco Use
- ☐ Sleep Apnea
- ☐ Family Hx Stroke
- ☐ Depression

History/Comments: _____

_____

_____

_____

_____

Investigation(s) (most recent):		**Date:(dd/mm/yy) / Location**
Carotid Ultrasound	☐ Yes ☐ No	_____
CT Head	☐ Yes ☐ No	_____
Echocardiogram	☐ Yes ☐ No	_____
Electrocardiogram	☐ Yes ☐ No	_____
Holter Monitor	☐ Yes ☐ No	_____
MRI/MRA	☐ Yes ☐ No	_____
Bloodwork (lipids)	☐ Yes ☐ No	_____

Medication(s) (include dose & frequency):

☐attach verified list of medications from ER triage or

☐ attach verified list of medications and patient profile from family doctor

_____

_____

_____

_____

Referring Physician Name: _____ **Phone:** _____

Signature: _____ **Billing number:**_____

Referral Date: _____ **Primary Care Provider:**_____

Please fax this form and copies of all investigations to: Stroke Prevention Clinic 519-272-8242
INCOMPLETE OR ILLEGIBLE FORMS MAY RESULT IN DELAYS

Revised (2016/09/26)