UNITY HEALTH TORONTO

TIA and Stroke Prevention Referral

□ **Urgent (See criteria below)**
□ **Standard**
Fax: 416-864-5712
Tel: 416-864-5056

Patient Information (or apply patient demographics sticker)
Last Name _____First Name _____
DOB (*dd/mmm/yyyy*) _____ Gender □ Female □ Male
Health card number_____ Version Code_____
Address_____
_____
Phone number _____Alternative number_____

Alternative contact person (Name/Phone)
_____
Suitable for virtual visit □ yes □ no
Email _____
Consent to email contact □ yes □ no
Interpreter required □ yes □ no
** If an interpreter is required, please ask patient to bring their own interpreter to avoid any delay in scheduling.*

Referring Physician Information
Name (*please print*):
Billing Number:
Family Physician:

Reason for referral:
□ TIA □ Stroke □ Carotid disease
□ Intracerebral hemorrhage
□ Other _____

Antithrombotic Therapy (check all that apply)
□ ASA □ Clopidogrel (Plavix)
□ Dipyridamole-ASA (Aggrenox)
□ Warfarin (Coumadin) □ DOAC_____

Stroke Risk Factors (check all that apply)
□ Previous stroke/TIA □ Carotid disease
□ Hypertension □ Smoking
□ Atrial fibrillation □ Dyslipidemia
□ Diabetes □ Coronary artery disease

Description of Event
Date(*dd/mmm/yyyy*) Duration □ minutes □ hours □days Did all symptoms resolve? □ yes □ no
Symptom (*Please check all that apply and circle the side if applicable*)

□ Speech disturbance	□ Imbalance/Vertigo	□ Headache
□ Motor weakness (R / L) □ *face* □ *arm* □ *leg*	□ Sensory disturbance (R / L) □ *face* □ *arm* □ *leg*	□ Visual disturbance (R / L) □ *monocular* □ *field loss* □ *diplopia*

Additional information

Criteria for Urgent Referrals (<72 hour turnaround time, 24-48 hours during week)

1. Patient with acute onset neurological symptoms with **complete recovery** (TIA) or **very mild residual deficits** (able to ambulate, care for themselves at home)
2. **Complete ALL of the following investigations**
   - ☐ CT and CTA of the head (arch to vertex) – **MUST BE COMPLETED (usually in the context of ED visit)** RESULT:_____
   - ☐ ECG **(fax actual ECG)** RESULT: _____
   - ☐ Lipids, glucose, HbA1C
   - ☐ Basic bloodwork: CBC, electrolytes, liver enzymes, creatinine
3. Blood pressure in ED: _____

Please fax completed referral and ED face sheet to 416-864-5712. Patient will be contacted within 72 hours. Please provide patient with the Patient Information Sheet (see Page 2). Unfortunately, we cannot accommodate urgent referrals without CTA/ECG at the moment. Incomplete referrals will be triaged as next available appointment.

For all patients, please attach the relevant clinical notes, list of medications and investigations (bloodwork, cardiac testing and neuroimaging) to the referral.

Signature_____ Date (mm/dd/yyyy) _____

Internal Use: *Triaged to Dr._____ *Urgency:* _____ *Date:* _____

St Michael's Hospital Rapid TIA and Minor Stroke Clinic

Patient Information Sheet

- ☐ You have been referred to the Rapid TIA and Minor Stroke Clinic.

- ☐ The Stroke Prevention Clinic will review the referral information and offer you either a virtual (by telephone or video) or in-person consultation by a stroke neurologist.

- ☐ You will be contacted within 24-48 hours (during the week) or on Monday if you present on a Friday, Saturday or Sunday.

- ☐ If you do not hear about an appointment within that time frame, please call the Stroke Prevention Clinic at: 416-864- 5056.

- ☐ If you experience sudden onset weakness, numbness/tingling, speech difficulties, vision changes or any other concerning symptoms, please seek urgent medical attention and call 9-1-1.

Internal Use: *Triaged to Dr._____ Urgency: _____ Date: _____*