ST. MICHAEL'S
UNITY HEALTH TORONTO

THE SCHROEDER BRAIN&HEART CENTRE

Stroke of Unknown Cause Clinic (SOCC) Program Referral Form

Brain & Heart Centre, 7th Floor, Donnelly Wing (Clinic Location)
30 Bond Street, Toronto, ON M5B 1W8
TEL: 416-864-5905 FAX: 416-864-5566

PATIENT'S LAST NAME:	FIRST NAME:	DATE OF BIRTH: DD/MM/YYYY
ADDRESS: APT#: CITY: POSTAL CODE:	HOSPITAL MRN:	
HOME NUMBER: CELL/OTHER NUMBER: EMAIL:	HEALTH CARD NUMBER: VERSION CODE:	GENDER: M F Other_____

URGENCY: ☐ URGENT: LESS THAN 2 WEEKS ☐ ELECTIVE: 3-6 WEEKS ☐ NON-URGENT >6WEEKS

REASON FOR REFERRAL – Patent foramen ovale (PFO)

PHYSICIANS	PLEASE INCLUDE THE FOLLOWING REPORTS AND CDS (IF AVAILABLE):
CARDIOLOGY **Sami Alnasser MD, FRCPC** Interventional and Structural Cardiology Division of Cardiology	☐ TEE/TTE: report and images on a CD ☐ 14 days holter monitor (30 day holter if patient is over 50 years old)
NEUROLOGY **Atif Zafar MD, FRCPC** Medical Director, Stroke Program Division of Neurology Assistant Professor, University of Toronto	☐ Brain MRI: report and images on a CD ☐ CT: report and images on a CD ☐ Stroke consult note
HEMATOLOGY **Eric Tseng MD, MScCH, FRCPC** Hematology & Thromboembolism Division of Hematology/Oncology Assistant Professor, University of Toronto	☐ Bilateral leg ultrasounds ☐ CBC, Creatinine bloodwork ☐ Hypercoagulable testing (ex. antiphospholipid antibodies, hereditary thrombophilia testing if available - not mandatory for referral)

CLINICAL INFORMATION:

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REFERRING PHYSICIAN NAME: (PRINT) BILLING #:	PHONE#: FAX#:
ADDRESS: CITY: POSTAL CODE:	
REFERRING PHYSICIAN SIGNATURE:	DATE: _____/_____/_____

CLINIC USE ONLY

DATE REFERRAL RECEIVED:	APPOINTMENT DATE:_____ TIME:_____