



Patient Information Name Unit number
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## Stroke Repatriation TOA/Reporting Form

Sending Location	West GTA Regional Stroke Centre – Trillium Health Partners Mississauga Site <input type="radio"/> ICU <input type="radio"/> Inpatient Ward _____
Reason for Repatriation	The patient was admitted for the following acute stroke treatment/investigations: and is now deemed ready for repatriation back to bypassed or home hospital <input type="radio"/> rt-PA <input type="radio"/> EVT <input type="radio"/> OTHER _____
Date of Event:	
Date of Transfer:	

Isolation requirement Y \_\_\_ N \_\_\_

Reason: \_\_\_\_\_

Code Status: Full code Y \_\_\_ N \_\_\_ If no then DNR on chart Y \_\_\_ N \_\_\_

**Stroke Specific Documentation/Information:**

- Lab/Diagnostics**  
 Date of most recent \_\_\_\_\_  
 Any abnormalities \_\_\_\_\_
- Diagnostic imaging completed? \_\_\_\_\_  
 Are images available by CD? Y \_\_\_ N \_\_\_
- Outstanding diagnostic imaging to be completed? \_\_\_\_\_
- Stroke Prevention Clinic/neurovascular follow-up appointment(s) location:
  - Trillium Health Partners
  - Other \_\_\_\_\_*\*If follow up at appointments are at Trillium Site please note these patients will be contacted by mail with their appointment information.*
- NIHSS last score \_\_\_\_\_
- STAND: Pass \_\_\_ Fail \_\_\_ Date completed \_\_\_\_\_ Current Diet \_\_\_\_\_
- AlphaFIM score \_\_\_\_\_ Date completed \_\_\_\_\_
- Speech: ex: does patient have aphasia? Y \_\_\_ N \_\_\_
- Deficits: ex: visual field deficits, mobility, transfers etc. \_\_\_\_\_

Sending Staff Physician (print)	Tel #:(MD/Inpatient unit)
Sending NP (print if applicable)	Tel #:
Receiving Staff Physician (print)	
Sending Nurse (print)	Receiving Nurse (print)



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