West GTA Regional Stroke Prevention Clinic Referral Form

100 Queensway West (Trillium Health Partners – Mississauga Hospital)
Mississauga, Ontario, L5K 2B5
(T) 905 848-7379 **(FAX) 905 848-7669**

Date Rcvd: ___/___/___

PLEASE NOTE: The target population is for patients who have had a TIA or minor stroke not requiring admission to hospital. ***For those who have chronic, longstanding symptoms and/or isolated syncope/dizziness/vertigo, please consider referring to general neurology or cardiology (for syncope)***

Carotid Bruit or know stenosis Referring Physician (PLEASE PRINT CLEEARLY)	Patient Name: _____
Hospital Affiliation: _____	Address: _____(City)
Office Phone Number: _____	Phone Number: _____
Office FAX Number: _____	Alternate Contact Number: _____
OHIP Referral Number: _____	Date of Birth ___/___/___ (D / M/ Y)
	OHIP Number:_____

Referring From: ☐ ED ☐ Family Practice ☐ Other: _____

☐ **Please book my patient for Carotid Dopplers (done with appointment in clinic)**

Required Information: Date of Event ___/___/___ (D/M/Y)
Age in years: _____
Blood Pressure: _____

Clinic Features: ☐ Motor Weakness ☐ Face L / R ☐ Arm L / R ☐ Leg L / R
☐ Speech Disturbance ☐ Aphasia ☐ Dysarthria

Duration of Symptoms: ☐ < 10 minutes ☐ 10-59 minutes ☐ > 60 minutes
Have the symptoms resolved? ☐ YES ☐ NO

Other clinic presentation: ☐ Sensory Disturbance ☐ Face L / R ☐ Arm L / R ☐ Leg L / R
☐ Amaurosis Fugax (loss of vision)
☐ Ataxia ☐ Limb ☐ Gait
☐ Carotid Bruit or know stenosis ☐ Right ☐ Left

Risk Factors (check all that apply)
☐ Atrial Fibrillation ☐ Hypertension ☐ Diabetes ☐ Current Smoker ☐ Hyperlipidemia
☐ Hx of CAD +/- PVD ☐ Previous TIA/Stroke ☐ Family hx of Heart/Stroke disease

FAX referral form and ALL current investigations/consults and blood work. <u>Our office will contact patients directly</u>