Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

STROKE NETWORK *of* Southeastern Ontario

REGIONAL STROKE PREVENTION CLINIC REFERRAL FORM
PHONE: (613) 549-6666 EXT. 6320
FAX: (613) 548-2537

CR#:
Name:
Date of Birth: *(yyyy mm dd)*
Health Card #:
Address:

Telephone# Home:
Work# or Alternate:
Family Physician:

IF SYMPTOMS OCCURRED WITHIN THE PAST 48 HOURS, THE PATIENT SHOULD BE ASSESSED IMMEDIATELY IN THE EMERGENCY DEPARTMENT AS PER CANADIAN BEST PRACTICE RECOMMENDATIONS.

Referring Physician:_____Office telephone_____Fax_____
(please print)

Date of Transient Ischemic Attack (TIA) /event: _____ **Date of Referral:** _____
(yyyy mm dd) *(yyyy mm dd)*

Referral Information: Symptoms experienced

□ Weakness: Left / Right_____
□ Sensory Change: Left / Right _____
□ Speech Disturbance: _____
□ Visual Change:_____
□ Other: _____
□ Duration of symptoms: _____

Risk Factors:

□ hypertension
□ coronary artery disease
□ smoking history
□ family history heart disease or stroke
□ atrial fibrillation
□ previous stroke or TIA
□ hyperlipidemia
□ diabetes
□ peripheral vascular disease
□ carotid stenosis
□ other: _____
_____

ALLERGIES/ADVERSE REACTIONS: _____

Please indicate tests that have been ordered

□ Copy of Emergency Record
□ Carotid Doppler
□ CT/CT angiogram
□ MRI/MR angiogram
□ ECG
□ Echocardiogram/ Holter
□ CBC
□ INR, PT, PTT
□ Electrolytes, Urea, Creatinine, ALT
□ Glucose (random)
□ Lipids
□ HbA1c

PLEASE ATTACH MEDICATION LIST AND FAX DIAGNOSTIC TEST RESULTS WHEN AVAILABLE. UPON RECEIPT REFERRALS WILL BE TRIAGED ACCORDINGLY.