North Bay Regional Health Centre | Centre régional de santé de North Bay

STROKE PREVENTION CLINIC REFERRAL FORM

50 College Dr, North Bay, ON P1B 5A4
Phone: 705-474-8600 **Fax: 705-495-8137**

Patient ID Label

IF PATIENT PRESENTS WITHIN 48 HOURS OF STROKE SYMPTOM ONSET, SEND PATIENT TO EMERGENCY DEPARTMENT.

THE REFERRING PHYSICIAN OR NURSE PRACTITIONER MUST COMPLETE THE FOLLOWING INFORMATION. INCOMPLETE/ILLEGIBLE REFERRALS MAY DELAY PATIENT APPOINTMENTS

PATIENT DEMOGRAPHICS:

Last Name:	First Name:	Date of Birth (DD/MM/YYYY): / /
Address:		Best Phone Number to Reach Patient:
Prov. Health Card No. & VC:		

□ **New Referral** □ **Post Discharge Follow-Up**

Reason for Referral:
□ TIA □ Stroke
□ Query TIA/Stroke □ Asymptomatic Carotid Stenosis
□ Other:

Most Recent Event:
□ Less than 48hrs □ Between 48hrs and 2 weeks
□ Greater than 2 weeks
Date of Most Recent Event: _____

Duration & Frequency of the Symptoms:
□ less than 10 mins □ Single episode
□ 10-59 mins □ Recurrent or fluctuating
□ 60 mins or more □ Persistent

Clinical Features *(Check (√) all that applies):*
□ Unilateral weakness:
□ Face □ Arm □ Leg □ Left □ Right
□ Unilateral sensory loss:
□ Face □ Arm □ Leg □ Left □ Right
□ Speech/language disturbance:
□ Aphasia □ Dysarthria
□ Acute Vision Change:
□ Monocular □ Hemifield
□ Binocular Diplopia
□ Ataxia
□ Vertigo **Must have one or more additional symptoms
□ Other: _____

Vascular Risk Factors *(Check (√) all that applies):*
□ Hypertension □ Dyslipidemia
□ Diabetes □ Cancer
□ Ischemic Heart Disease
□ History of Atrial Fibrillation
□ Previous Stroke or TIA
□ Previous known Carotid Disease
□ Peripheral Vascular Disease
□ History of Thrombosis
□ History of Sleep Apnea
□ Smoking/Vaping: □ Current □ Past
□ Alcohol Abuse □ Drug Abuse
□ Other: _____

Diagnostic Investigations:
□ Ordered □ Results attached

Investigations	Location Ordered
□ CTA (head & neck)	
□ CT (head) □ MRI (head) □ Carotid Doppler/Ultrasound (neck)	
□ MRA (head & neck)	
□ ECG	
□ Echocardiogram	
□ Holter Monitor	
□ Bloodwork (CBC, Lytes, eGFR, A1C, Lipids, ALT)	
□ Other:	

Consults:
□ None □ Ordered □ Report attached
□ Vascular Surgery or Neurosurgery for Carotid Stenosis
□ Ophthalmology
□ Other: _____

Medications Initiated post event:
□ Antiplatelet therapy: □ ASA □ Plavix □ Other:
□ Anticoagulant:
□ Other: _____

Other relevant clinical information: _____

Referral Source:
□ Primary Care Family Physician or Nurse Practitioner
□ ED Physician □ Specialist
□ Inpatient Unit □ Other:

Referral Practitioner Name: _____
Signature: _____
Phone: _____
OHIP Billing Number: _____