Pembroke Regional Hospital

STROKE PREVENTION CLINIC REFERRAL FORM

Addressograph

Phone: 1-613-732-3675 Ext. 6640
1-855-293-7838

FAX: 1-613-732-6350
1-855-293-7839

Referral Source: ☐ Emergency Department ☐ Physician's Office ☐ Specialist ☐ Other

Date of Event: ___________________(yyyy/mm/dd)

Family Physician: __________________________

Reason for Consultation:

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Signs and Symptoms: See the *TIA Management in the Emergency Department Algorithm*

Symptom duration: ☐ Less than 10 minutes ☐ 10-59 minutes ☐ Greater than 60 minutes

Risk Factors (Current or Past History):

☐ Hypertension	☐ Smoking
☐ PVD	☐ Dyslipidemia
☐ CAD	☐ Previous Stroke/TIA
☐ Diabetes	☐ Sleep Apnea
☐ Atrial Fibrillation	☐ Carotid Stenosis

Medications:

Anti-platelet:	**Anticoagulant:**
☐ ASA	☐ Warfarin
☐ Clopidogrel	☐ Dabigatran
☐ Aggrenox	☐ Rivaroxaban
	☐ Apixaban

Other: ____

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Completed/Scheduled Tests (please attach all completed reports)**:**

☐ CT	☐ ECG	☐ MRI	☐ Echocardiogram
☐ CTA	☐ Carotid Doppler	☐ Holter	☐ Bloodwork

Referring Physician: ______________________________ **Signature:** ___________________________________

Date: ___________________________