Regional Stroke Program
Programme régional des AVC
CHAMPLAIN

Stroke Prevention Clinic Consultation Form

The Ottawa Hospital
Civic Campus

Phone: (613) 798-5555 ext 16156
Fax: (613) 761-5320

Name:
DOB:
OHIP#:
Telephone # (home):
Telephone # (work/other):
Address:
Family Physician:

In order to provide appropriate care for your patient, we request that the following consult be filled in, *in its entirety*. *Incomplete forms will cause delay in processing.*

Reason for referral: **Date:** _____

_____

_____

_____

DATE of Transient Ischemic Attack/Minor Stroke : _____ (yyyy/mm/dd)

Blood Pressure: **1. At time of event (if known)** _____
2. Current BP:_____

Signs/Symptoms suggesting TIA/Minor Stroke: (side R or L)				**Risk factors:**	
Unilateral motor deficit (s)	□ yes	□ no	**R or L**	□ Previous Stroke/TIA	□ Pregnancy
Unilateral numbness or tingling	□ yes	□ no	**R or L**	□ Hypertension	□ Smoking
Aphasia	□ yes	□ no		□ Atrial fibrillation	□ Obesity
Dysarthria	□ yes	□ no		□ Dyslipidemia	□ Sedentary lifestyle
Amaurosis fugax	□ yes	□ no	**R or L**	□ Diabetes	□ Alcohol abuse
Hemianopia	□ yes	□ no		□ CAD/PVD	□ Drug abuse
Other	_____			□ Asymptomatic carotid stenosis	
Duration of symptoms	□ <10 min	□ 10-59 min	□ >60min	□ Other _____	

<u>Investigation (s)</u>: If an Echo, Doppler or Fasting Bloodwork has not been performed, the SPC will arrange and expedite these tests for your patient. If a CT Head has not been ordered, please send a completed/signed CT Head requisition for the SPC to expedite. Please include any recent diagnostic/lab results or reports (<6 months)

□ CT head *_____ □ Echocardiogram/TEE_____ □ Fasting glucose_____ □ CBC_____

□ Carotid Doppler_____ □ Holter monitor_____ □ Fasting lipid profile-LDL_____ □ INR/PTT_____

□ ECG_____ □ MRI/MRA_____ □ Electrolytes_____Urea_____Creatinine_____

***If completed outside of TOH, please advise patient to bring a copy of the CT head on CD**

□ LFTs/CK_____

Current Medication (s):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Referring Physician: _____/_____

(Print) (Signature)

Private Telephone #: _____ **Fax:** _____

Fax this completed form with available results. Upon receipt referrals will be triaged accordingly.