Regional Stroke NETWORK Réseau Régional DES AVC CHAMPLAIN

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

Stroke Prevention Clinic Consultation Form

Cornwall Community Hospital - McConnell site
840 McConnell Ave, Cornwall ON K6H 5S5
Phone: (613) 938-4240 ext 3118
Fax: (613) 938-5379

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.*

Referred from: ☐ Emergency ☐ Physician's Office ☐ Inpatient Unit ☐ Other Hospital ☐ Other _____

Date: _____ **Family physician: Dr** _____

REASON FOR REFERRAL: ☐ Transient Ischemic Attack (TIA) ☐ Risk Factor Management ☐ Post-Stroke Follow-up

Comments:

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

BP at time of event (if known): _____ **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 _____

Investigation (s): Check all that have been ordered. Indicate time and location of all tests (including those pending). Please include copies of any recent diagnostic/lab reports (<6 months)

☐ CT head * _____	☐ Echocardiogram/TEE _____	☐ Fasting glucose	☐ CBC
☐ Carotid Doppler _____	☐ Holter monitor _____	☐ Fasting lipid profile	☐ INR/PTT
☐ ECG _____	☐ MRI/MRA _____	☐ Electrolytes/Urea/Creatinine/LFTs/CK	

- ***Please advise patient to bring a copy of the CT head on CD (if available).**
- **If a CT Head has not yet been ordered please send a completed/signed CT Head Requisition for the SPC to expedite.**

Medications Initiated: ☐ Aggrenox ☐ Anti-coagulant: _____ ☐ ASA ☐ Plavix ☐ Statin

Current Medication(s):

Referring Physician: _____ / _____
(Print) (Signature)

Office telephone: _____ **Fax:** _____

Fax this completed form to 613-938-5379 with all available results. Upon receipt, referrals will be triaged accordingly.