

STROKE PREVENTION CLINIC REFERRAL



Patient Information:
 Name: _____
 DOB: _____
 Phone Number: _____
 Insurance Coverage: _____
 Email: _____
 Address: _____

RVH Stroke Prevention Clinic
 201 Georgian Drive, Barrie, ON
 Phone: 705-728-9090 Ext. 46315
Fax: 705-797-2930

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

THE FOLLOWING INFORMATION MUST BE COMPLETED

Referral Type:

Reason for Referral

- TIA Stroke Query TIA/Stroke
 Carotid Stenosis Other: _____

Date & Time of Most Recent Event: _____

Duration & Frequency of the Symptoms:

- <10 mins 10 - 59 mins 60 mins or more
 Single episode Recurrent or fluctuating Persistent

Clinical Features: Check (✓) all that apply

- Unilateral weakness (face arm leg) L R
 Unilateral sensory loss (face arm leg) L R
 Speech/language disturbance (e.g., slurred; expressive/word finding difficulty)
 Acute Vision Change (Monocular Hemifield Binocular Diplopia)
 Ataxia
 Other: _____

Vascular Risk Factors: Check (✓) all that apply

- Hypertension Previous known Carotid disease
 Dyslipidemia Peripheral Vascular Disease
 Diabetes Current smoking/vaping
 Ischemic Heart Disease Past smoking/vaping
 History of Atrial Fibrillation Alcohol Abuse
 Previous Stroke or TIA Drug Abuse
 Other: _____

Medications (attach list)

Medication(s) initiated post event:

- Antiplatelet therapy: _____
 Anticoagulant: _____
 Other: _____

Diagnostic Investigations Ordered or Results Attached:

(Do not delay referral to SPC if investigations not done)

Investigations	Date	Location
<input type="checkbox"/> CT (head) <input type="checkbox"/> CTA (head & neck)		
<input type="checkbox"/> MRI (head) <input type="checkbox"/> MRA (head & neck)		
<input type="checkbox"/> Carotid Doppler / Ultrasound		
<input type="checkbox"/> ECG		
<input type="checkbox"/> Echocardiogram		
<input type="checkbox"/> Holter / Event Monitor		
<input type="checkbox"/> Bloodwork		
<input type="checkbox"/> Other:		

Has Patient ever been referred or consulted by:

(Attach consult report if available):

- SPC Neurology Vascular Surgery (for Carotid Stenosis)
 Neurosurgery Other: _____

Referral Criteria: All patients with a TIA or nondisabling minor stroke who present to a primary care provider, an ED and are discharged, or hospitalized with a stroke or TIA, should be referred to a Stroke Prevention Clinic (SPC). SPC is an outpatient clinic for individuals who have signs and symptoms of a recent stroke or TIA. The goal is to reduce incidence of future stroke. At RVH, SPC physicians include *Internists and Neurologists*. If your patient's concern is more suited to general Neurology evaluation, please refer to Neurology directly.

Concurrent Referral Recommendations:

- **Carotid Stenosis Consultation Recommendations:**
 Concurrent referral for Urgent consultation with Vascular Surgery for Stroke or TIA with 50-99% carotid stenosis. Consider concurrent elective referral to vascular surgery if there is remotely symptomatic (e.g., greater than 6 months) or asymptomatic carotid stenosis. Ensure CTA or MRA completed to confirm candidacy for carotid intervention on patients that are symptomatic, prior to consult with a vascular surgeon.
- Consider concurrent referral to ophthalmology for visual concerns and referral to community stroke rehabilitation program if there are rehabilitation needs.

Key Best Practices:

- <https://www.strokebestpractices.ca/recommendations/secondary-prevention-of-stroke>
- See info above re: mild to high grade carotid stenosis
- Antithrombotic therapy prevents stroke.
- Patients with confirmed TIA or ischemic stroke should start antiplatelet therapy unless anticoagulation indicated

Key Health Teaching:

- Review Signs of Stroke & when to call 911.
- Discuss the need to refrain from driving.
 Refer to patient handout available at <https://cesnstroke.ca/cesn-driving-after-stroke-or-tia/>
- Provide TIA/Stroke Education package (if applicable).

Additional Information: (e.g., allergies, code status ...)

Referral Source:

Referral Name: _____
Organization/ Facility: _____
OHIP Billing #: _____
Referral Date: _____
Signature: _____

Fax completed form to 705-797-2930 or click on the "Submit Form to SPC" button to submit by email. Upon receipt, referral will be triaged accordingly, and patient contacted directly with appointment date and time. For general information on triage process, follow link: <https://cesnstroke.ca/spc-triage/> or QR code.

