TIMMINS AND DISTRICT HOSPITAL
L'HÔPITAL DE TIMMINS ET DU DISTRICT

Demographic Label

Secondary Stroke Prevention Clinic Referral Form

The following information **MUST** be completed. Incomplete forms will be returned.
Fax the completed form and any attachments to **(705) 360-6097**

Patient _____ Best Phone Number to Reach Patient _____

Referring Physician _____ Family Physician _____

Referring Physician Signature _____ OHIP Billing No. _____

Date of Event _____ Referral Date _____

Reason for Referral _____

Tests Completed or Pending

CT Head	☐ Complete	
CTA (recommended within 24 hours of presentation)	☐ Complete	☐ Pending
MRI/MRA	☐ Complete	☐ Pending
Carotid Ultrasound	☐ Complete	☐ Pending
ECG	☐ Complete	☐ Pending
Relevant Bloodwork (including HbA1c and lipid profile)	☐ Complete	☐ Pending
Echocardiogram	☐ Complete	☐ Pending
Holter Monitor (consider m-Health Solutions)	☐ Complete	☐ Pending

- Referral Sent To: _____

Clinical Features

☐ **Unilateral Weakness** ☐ Face ☐ Arm ☐ Leg Affected Side: ☐ Right ☐ Left
☐ **Unilateral Sensory Symptoms** ☐ Face ☐ Arm ☐ Leg Affected Side: ☐ Right ☐ Left
(Must affect two contiguous segments)
☐ **Visual Loss** Affected Side: ☐ Right ☐ Left
☐ **Speech Disturbances**
☐ **Other:**
☐ **Duration of Symptoms:**
- ☐ Less than 10 minutes
- ☐ 10–59 minutes
- ☐ 60 minutes or more

Risk Factors

☐ Hypertension
☐ History of Atrial Fibrillation
☐ Diabetes
☐ Hyperlipidemia
☐ History of Sleep Apnea
☐ Ischemic Heart Disease; previous CABG (Year): _____
☐ Previous Stroke or TIA; Date: _____
☐ Previous or Known Carotid Disease: ☐ L ☐ R _____%stenosis
☐ Current Smoker / ☐ Ex-Smoker

Treatment Initiated

☐ Antiplatelet Therapy _____	☐ Started	☐ Continued
☐ Anticoagulant _____	☐ Started	☐ Continued
☐ ACE Inhibitor or ARB _____	☐ Started	☐ Continued
☐ Statin _____	☐ Started	☐ Continued
☐ Other _____		