Lakeridge Health

Stroke Prevention Clinic Referral

Event Date: _____

Symptom Duration: _____

Note: High risk patients should be directed to the nearest Emergency Department for evaluation

Very High Risk	High Risk	Moderate Risk
Onset within 48 hours AND following symptoms (check all that apply): ☐ Unilateral weakness (face, arm and/or leg). Indicate side: R or L ☐ Speech disturbance/aphasia ☐ Hemibody sensory symptoms ☐ Monocular visual loss ☐ Posterior circulation: binocular diploplia, dysarthria and/or ataxia	**Onset between 48 hours and 2 weeks AND following symptoms (check all that apply):** ☐ Unilateral weakness (face, arm and/or leg). Indicate side: R or L ☐ Speech disturbance/aphasia	**Onset between 48 hours and 2 weeks AND following symptoms (check all that apply):** ☐ Hemibody sensory symptoms ☐ Monocular or Binocular vision loss ☐ Binocular diplopia ☐ Hemifield vision loss ☐ Ataxia ☐ Other: _____
Investigations suggested to be completed in the Emergency Department. Check if completed: ☐ CT Head ☐ CTA OR Carotid Doppler ☐ 12 lead ECG ☐ CBC, PTT/INR, lytes, Cr, Glu, LFTs, Trop ☐ Validated Swallowing Screen	**Investigations suggested to be completed in the Emergency Department. Check if completed:** ☐ CT Head ☐ CTA OR Carotid Doppler ☐ 12 lead ECG ☐ CBC, PTT/INR, lytes, Cr, Glu, LFTs, Trop ☐ Validated Swallowing Screen	**Investigations suggested to be completed within 2 weeks. Check if ordered:** ☐ CT Head ☐ CTA OR Carotid Doppler ☐ 12 lead ECG ☐ CBC, lytes, Cr, Glu, HbA1C, TSH, PTT/INR, LFTs, Chol. Profile

Low Risk: Symptom onset beyond 2 weeks or atypical

Describe Symptoms: _____

Investigations suggested to be completed within 1 month. Check if ordered:

☐ CT Head/CTA ☐ 12 lead ECG ☐ CBC, HbA1C, TSH, PTT/INR, lytes, Cr, Glu, LFTs, Chol. Profile

Anti−thrombotic on Discharge

☐ ASA ☐ Plavix

☐ DOAC (Direct oral anticoagulant) ☐ Aggrenox

☐ None (please state reason):

_____

☐ A−Fib

☐ Other: _____

Other Investigations Ordered and Referrals

☐ MRI ☐ Echo ☐ Holter hr ____

☐ Referral made to Vascular Surgery on−call for carotid stenosis greater than 50% OR moderate to severe stenosis

Primary Care Provider: _____ **Date:** _____

Referring Provider: _____ / _____

Please Print Name **Signature**

FAX referral to the Stroke Prevention Clinic 905−721−7797 (include all results and ER Record)