fraserhealth

STROKE PREVENTION CLINIC REFERRAL

Bar Code Area

Patient Data

Bar Code Area

MSXX102039E May 15, 2020

Clinic Location Requested: ❑ JPOSC (Surrey) **(604) 875-5295** ❑ RCH (New West) **(604)-520-4661**
❑ ARH (Abbotsford) **(604)-851-4964** ❑ Next available clinic

PHYSICIAN: PLEASE COMPLETE ALL SECTIONS and Fax to: 604-528-5433

REFERRAL INFORMATION:

Referring Health Care provider:
Name: _____
Title: _____ Source: _____
MSP#: _____
Phone: _____ Fax: _____

Patient Name: _____
Address: _____
Phone: _____
Email: _____

Reason for Referral: **Date/Time of symptom onset:** _____/_____

Symptom History: ❑ **First episode** ❑ **Recurrent episodes**

Please specify neurologic symptoms and their duration_____

_____

Relevant Medical History: _____

_____

ABCD² Scoring

		POINTS
Age	❑ ≥ 60 years old	**1**
Blood Pressure	❑ Systolic ≥ 140 mm Hg and/or Diastolic ≥ 90 mm Hg	**1**
Clinical Features	❑ Unilateral weakness	**2**
	❑ Speech disturbance without weakness	**1**
	❑ Other	**0**
Duration of Symptoms	❑ ≥ 60	**2**
	10 – 59 minutes	**1**
	❑ < 10 minutes	**0**
Diabetes	❑ Diabetes Mellitus	**1**
	TOTAL SCORE	

Score	2-Day Risk of Stroke	Risk	Target Referral Time
0 - 3	1%	Low Risk	48 to 72 hours
4 - 5	4.1%	Higher Risk	24 to 48 hours
6 - 7	8.1%	Consider Admission	Immediate

Physicians Notes:

Print Shop #255378

fraserhealth

STROKE PREVENTION CLINIC REFERRAL

Bar Code Area

MSXX102039E May 15, 2020 Page: 2 of 2

Patient Data

Bar Code Area

PHYSICIAN: PLEASE COMPLETE ALL SECTIONS

MEDICATIONS PRESCRIBED

- ❑ **Enteric Coated ASA 81 mg daily**
- ❑ **Warfarin (INR:_____)**
- ❑ **Other:** _____
- ❑ **Clopidogrel 75 mg daily (requires Special Authority from Pharmacare)**
- ❑ **DOAC:** _____

Isolation Precautions ❑ Airborne ❑ Contact ❑ Droplet ❑ None

Interpreter Required: ❑ No ❑ Yes If yes, specify language: _____

Has this patient been seen by a neurologists previously? ❑ No ❑ Yes (if yes, attach consult)

If Stroke is suspected, ensure vascular imaging is complete.

Investigations Ordered: ❑ CT Head ❑ CTA Head/Neck ❑ Echocardiogram ❑ Holter Monitor

Investigations Complete: ❑ CT Head ❑ CTA Head/ Neck ❑ Echocardiogram ❑ Holter Monitor

**Ensure report attached to this referral*

Physician notes:

Physician's signature:_____ **Date/Time:**_____/_____

Print Shop #255378