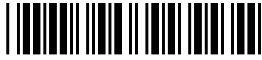
fraserhealth

STROKE PREVENTION CLINIC REFERRAL



FAX to JPOCSC Central Intake (604-953-9701)

NOTE: FAX STROKE PREVENTION CLINIC REFERRAL with this form

PATIENT INFORMATION:

Patient's Name: ______________________ **Gender:** ________
Last First Middle

Date of Birth: ____/____/______ **PHN:** ____________ **Insurance:** ________
(DD/MM/YYYY)

Address: ____
Street City Province Postal Code

Contact Method Primary: ____________ **Alternate:** ____________

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**	**Referring Health Care Provider:** **Name:** ____________ **Title:** ____________ **Source:** ____________ **MSP #:** ____________ **Phone:** ____________ **Fax:** ____________

Reason for Referral: ____

____

Medical Reason for Urgency: ____

____

Relevant Medical History: ____

____

Isolation precautions ☐ **Airborne** ☐ **Contact** ☐ **Droplet** ☐ **None**

Interpreter Required ☐ **No** ☐ **Yes** **If yes, specify language** ____________

Referral Clinic: Stroke Prevention Clinic

Referring Health Care Provider Signature: ____________ **Date:** ____________

Has this patient been seen by a neurologist previously? ☐ **Yes** ☐ **No (if Yes, please attach consult)**

Neurologist seen: ____________

This facsimile is directed in confidence and is intended for use by the individual or entity to which it is it specifically addressed. Any other distribution, copy, or disclosure is strictly prohibited. The contents of this facsimile may also be subject to privilege and all rights to that privilege are expressly claimed and not waived. If you have received this facsimile in error, please notify us immediately by telephone. Thank you for your co-operation.

fraserhealth

STROKE PREVENTION CLINIC REFERRAL Cont'd

Clinic Location Requested: ☐ JPOCSC (Surrey) ☐ RCH (New West) ☐ ARH (Abbotsford) ☐ Next available clinic

Referring Physician: ______________________ **Referral Source:** ______________________

PHYSICIAN: PLEASE COMPLETE ALL SECTIONS

1. CLINICAL FEATURES:

Date/Time of onset: ______________________ / ______________

Symptom History: ☐ First Episode ☐ Recurrent Episodes ☐ Visual TIA

2. RISK STRATIFICATION for EARLY STROKE

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 minutes	**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

3. MEDICATIONS PRESCRIBED

☐ **Enteric Coated ASA 81 mg daily**

☐ **ASA-Dipyridamole (Aggrenox) one capsule BID**

☐ **Clopidogrel 75 mg daily (requires Special Authority from Pharmacare)**

☐ **Other:** ______________________

Physician's signature: ______________________ **Date/Time:** ______________ / __________

Physicians Notes:

Investigations Ordered: **CT Head** ☐ **Carotid Ultrasound** ☐ **Echocardiogram** ☐

Print Shop #255378