fraserhealth

STROKE PREVENTION CLINIC REFERRAL

Form ID: MSXX102039F

PHYSICIAN: PLEASE COMPLETE ALL SECTIONS

FAX Referral to:

- ☐ **JPOCSC (Surrey Clinic) 604-528-5433** T: (604)-582-4550 ext 763870 (SMH, LMH, PAH, DH regions)
- ☐ **RCH (New West Clinic): 604-520-4188** T: (604)-520-4661 (RCH, ERH, RMH, BH regions)
- ☐ **ARH (Abbotsford Clinic): 604-851-4774** T: (604)-851-4964 (ARH, CWH, MMH, FC regions)

REFERRAL INFORMATION:

Referring Health Care Provider: Name:_____ Title:_____ Source:_____ MSP#:_____ Phone:_____ Fax:_____	Patient Name:_____ Address:_____ Phone:_____ Email:_____ PHN:_____ DOB:_____

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

Symptom History: ☐ First episode ☐ Recurrent episodes

Please specify neurologic symptoms and their duration_____

Relevant Medical History:_____

	Risk Scoring	SPC Appointment Priority
☐	VERY HIGH risk for recurrent stroke: patients who present with stroke symptom onset within last 48 hours →send to ER for urgent imaging (CT/CTA head and neck) and ECG. If no carotid stenosis and no occlusion, refer to stroke clinic. If stenosis or occlusion present, admit to hospital.	Send patient to ER for urgent imaging (CT/CTA head and neck) and ECG
☐	HIGH risk for recurrent stroke: patients who present between 48 hrs and 2 weeks from onset with transient, fluctuating, or persistent unilateral weakness or speech disturbance/aphasia	As soon as possible within 24 hours
☐	MODERATE risk for recurrent stroke: patients who present between 48 hrs and 2 weeks with stroke-like symptoms other than unilateral motor weakness or speech disturbance	Within 2 weeks
☐	LOWER risk for recurrent stroke: patients who present more than 2 weeks after symptom onset	>2 weeks - 1 month

Physicians Notes (including pending investigations):_____

STROKE PREVENTION CLINIC REFERRAL (cont'd)

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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 ☐ Other

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 (including pending investigations):

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