



STROKE PREVENTION CLINIC REFERRAL



Form ID: MSXX102039G

Rev: September 20, 2021

Page: 1 of 2

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): 604-851-4964** 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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



Form ID: MSXX102039G

Rev: September 20, 2021

Page: 2 of 2

MEDICATIONS PRESCRIBED

Enteric Coated ASA 81 mg daily

Clopidogrel 75 mg daily (requires Special Authority from Pharmacare)

Warfarin (INR: _____)

DOAC: _____

Other: _____

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: _____ / _____