Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

TIA/Stroke/Neurology Clinic Community Referral Form

Name: _____
Last, First Name

Gender: ☐ Male ☐ Female Date of Birth: _____
dd/mm/yyyy

Health Card No. _____Version Code: _____

Address:_____
_____

Telephone No. _____

Fax referral form, all diagnostic investigations and blood work to 905-883-0772
Clinic Telephone Number: 905-883-1212/905-832-4554 Ext. 7721

Please check which clinic the referral is being directed to and complete all required information in order for the referral to be processed.

☐ TIA/Stroke Clinic

Symptoms localized to anterior circulation

Unilateral Weakness ☐ Yes ☐ No ☐ Right ☐ Left (☐ Face ☐ Arm ☐ Leg)

Amaurosis Fugax (Transient Loss of Vision in One Eye) ☐ Yes ☐ No ☐ Right ☐ Left

Speech disturbances ☐ Yes ☐ No

Duration of symptom(s):
- ☐ Seconds
- ☐ 1 minute – 10 minutes
- ☐ 10 minutes – 60 minutes
- ☐ Greater than 60 minutes
- ☐ Still persisting

Symptoms occurred within:
- ☐ Past 24 hours
- ☐ 24 hours – 48 hours ago
- ☐ 72 hours – 1 week ago
- ☐ 1 week – 2 weeks ago
- ☐ 2 weeks – 4 weeks ago
- ☐ Greater than 4 weeks ago

Incidental stroke on CT/MRI of Brain ☐ Yes ☐ No

☐ Neurology Clinic

Please check the most appropriate reason for referral
- ☐ Headache
- ☐ Vertigo
- ☐ Parkinsonism/Movement Disorders
- ☐ Botox Consultation, Please complete page 2
- ☐ Multiple Sclerosis/Demyelination
- ☐ Seizure/Epilepsy
- ☐ Other, please describe _____

General Comments: _____
_____

Referring Physician Name (Please Print)	Referring Physician Billing No.	Address
Referring Physician Signature	Date of Referral (dd/mm/yyyy)	

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Patient Label Here

TIA/Stroke/Neurology Clinic
Community Referral Form

☐ Chronic Migraine Or Movement Disorder Consultation Request for Botox Injection Treatment Consideration

Diagnosis: Reason for Referral (check one)

☐ Chronic/Frequent Migraine

☐ Movement Disorder: please circle (Cervical Dystonia, Hemifacial Spasm, Blepharospasm, Other: _____)

For Chronic Migraine – **Please check that patients being referred to the injection clinic meet these criteria**

☐ Secondary headache causes have been ruled out

☐ Diagnosed with Chronic Migraine (>15 headache days/month with > 8 being features of migraine)

☐ Established patient has failed or is not suitable with 1-2 other prophylactic intervention (please list in below section)

☐ Patient is amenable to this alternative therapy to headache treatment

☐ Patient has insurance coverage for prophylactic treatment

Important Medical History (allergies, family history of disease etc.): _____

_____

_____

_____

MRI/CT Scan completed: Date: _____(dd/mm/yyyy) Comments _____

Previous Therapies Tried: _____

_____

_____

_____

_____

Print Form