

## TIA/Stroke/Neurology Clinic Community Referral Form

Name: _____ <div style="text-align: right; font-size: small;">Last, First Name</div>
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female    Date of Birth: _____ <div style="text-align: right; font-size: small;">(yyyy/mm/dd)</div>
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 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

TIME FROM SYMPTOM ONSET (please check)	CLINICAL FEATURES (please check)	RISK CATEGORY	ACTION
<input type="checkbox"/> Within 48 hours	Any listed below (please check all that apply)	Very High	Send to nearest emergency department immediately for investigation (CT/CTA arch to vertex, ECG, bloodwork). Then complete the referral.
<input type="checkbox"/> 48 hours – 2 weeks	<input type="checkbox"/> Unilateral weakness <div style="margin-left: 20px;"><input type="checkbox"/> Face   <input type="checkbox"/> Arm   <input type="checkbox"/> Leg</div> <div style="margin-left: 20px;"><input type="checkbox"/> Right   <input type="checkbox"/> Left</div> <input type="checkbox"/> Speech disturbance	High	Send to nearest emergency department within 24 hours for investigations (CT/CTA arch to vertex, ECG, bloodwork). Then complete the referral.
	<input type="checkbox"/> Unilateral sensory disturbance <input type="checkbox"/> Monocular/hemifield Vision loss <div style="margin-left: 20px;"><input type="checkbox"/> Right   <input type="checkbox"/> Left</div> <input type="checkbox"/> Symptoms suggestive of posterior circulation event (diplopia, dysarthria, dysphagia, ataxia)	Moderate	Complete this referral
<input type="checkbox"/> Greater than 2 weeks	Any of above (please check all that apply)	Lower	Complete this referral

**Duration of Symptoms**

- < 10 min
- 10-59 min
- > 60 min
- Persistent

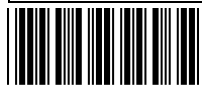
**CT/MRI findings**

- Not yet performed
- No infarct
- Old infarct
- Acute/new infarct

**Medication**

- |                                    |                                    |
|------------------------------------|------------------------------------|
| Antiplatelet                       | Anticoagulant                      |
| <input type="checkbox"/> Initiated | <input type="checkbox"/> Initiated |
| <input type="checkbox"/> Continued | <input type="checkbox"/> Continued |

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



**TIA/Stroke/Neurology Clinic  
Community Referral Form**

**Neurology Clinic**

Name: _____ Last, First Name	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____ (yyyy/mm/dd)
Health Card No. _____ Version Code: _____	
Address: _____ _____	
Telephone No. _____	

Please check the most appropriate reason for referral:

- |   |   |
|---|---|
| <input type="checkbox"/> Headache   | <input type="checkbox"/> Multiple Sclerosis/Demyelination |
| <input type="checkbox"/> Vertigo  | <input type="checkbox"/> Seizure/Epilepsy                 |
| <input type="checkbox"/> Parkinsonism/Movement Disorders                  | <input type="checkbox"/> Other, please describe _____     |
| <input type="checkbox"/> Botox Consultation, please complete <u>below</u> |   |

Botox Consultation for Movement Disorder (please check)

- Cervical Dystonia
- Hemifacial Spasm
- Blepharospasm
- Other: \_\_\_\_\_

Botox Consultation for Chronic Migraine, (**please check that patients being referred to the injection clinic meet ALL these criteria**)

- Secondary headache causes have been ruled out  
MRI/CT date \_\_\_\_\_ (dd/mm/yyyy) and findings: \_\_\_\_\_
- Diagnosed with chronic migraine (>15 headache days per month with > 8 having features of migraine)
- Patient has failed or is not suitable with 1-2 other prophylactic interventions  
Previous therapies tried: \_\_\_\_\_
- Patient is amenable to this alternative therapy
- Patient has insurance coverage

**General Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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