Regional Stroke Program
Programme régional des AVC
CHAMPLAIN

Stroke Prevention Clinic Consultation Form

The Ottawa Hospital
Civic Campus

Phone: (613) 798-5555 x16156
Fax: (613) 761-5320

Name:
DOB:
OHIP#:
Telephone # (home):
Telephone # (work/other):
Address:
Family Physician:

Due to the large numbers of referrals, we request that the following consult be filled in, in its entirety. Incomplete forms will cause delay in processing.

Reason for referral: **Date:** _____

_____

_____

If a Transient Ischemic Attack (TIA)/Minor Stroke, please indicate date of event: _____ (yyyy/mm/dd)

Signs/Symptoms suggesting TIA/Minor Stroke: (side R or L)

Unilateral motor deficit (s)	yes	no	R or L
Unilateral numbness or tingling	yes	no	R or L
Aphasia	yes	no	
Dysarthria	yes	no	
Amurosis fugax	yes	no	
Hemianopia	yes	no	
Duration of symptoms (minutes)	<10	10-59	>60
Have symptoms resolved	yes	no	

Risk factors:

Previous Stroke/TIA	Pregnancy
Hypertension	Current Smoker
Atrial fibrillation	Obesity
Dyslipidemia	Drug abuse
Diabetes	Alcohol abuse
CAD/PVD	Other_____
Asymptomatic carotid stenosis	_____

Investigation (s):Please check all that have been ordered. Please indicate time and location of all tests (including those pending).
Please include lab results done in the ED and ECG interpretation.

CT head *	Echocardiogram/TEE	Fasting glucose	Plat._____
Carotid Doppler	Holter monitor	Fasting lipid profile	INR/PTT_____
ECG_____	MRI/MRA*	Crea_____	Urea_____
		CK _____	ALT_____AST_____

_____

_____

* **Please advise patient to bring a copy of the CT head /MRI on CD for those not completed at TOH**

Current Medication (s): **Meds started in ED**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Referring Physician: _____/_____
(Print) (Signature)

Office telephone: _____ **Fax:** _____

Fax this completed form with available results. Upon receipt referrals will be triaged according to published criteria ABCD² score
(Johnston, Rothwell et al., The Lancet, 369, January 27, 2007).