

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

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Antiplatelet | <input type="checkbox"/> 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: Male Female Date of Birth: _____
(yyyy/mm/dd)

Health Card No. _____ Version Code: _____

Address: _____

Telephone No. _____

Please check the most appropriate reason for referral:

- Headache
- Vertigo
- Parkinsonism/Movement Disorders
- Botox Consultation, please complete below
- Multiple Sclerosis/Demyelination
- Seizure/Epilepsy
- Other, please describe _____

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: _____

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