Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905 883 1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-7000

TIA/Stroke/Neurology Clinic Community Referral Form

Name: _____
Last, First Name

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

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
☐ 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.
☐ 48 hours – 2 weeks	☐ Unilateral weakness ☐ Face ☐ Arm ☐ Leg ☐ Right ☐ Left ☐ Speech disturbance	High	Send to nearest emergency department within 24 hours for investigations (CT/CTA arch to vertex, ECG, bloodwork). Then complete the referral.
	☐ Unilateral sensory disturbance ☐ Monocular/hemifield Vision loss ☐ Right ☐ Left ☐ Symptoms suggestive of posterior circulation event (diplopia, dysarthria, dysphagia, ataxia)	Moderate	Complete this referral
☐ 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 infract

Medication
Antiplatelet
☐ Initiated
☐ Continued

Anticoagulant
☐ Initiated
☐ Continued

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

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10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Name: _____
Last, First Name

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

Health Card No. _____ Version Code: _____

Address: _____

_____

Telephone No. _____

TIA/Stroke/Neurology Clinic Community Referral Form

☐ Neurology Clinic

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)

- ☐ Certival Dystonia
- ☐ Hemifacial Spasm
- ☐ Blepharospam
- ☐ 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 tired: _____
- ☐ 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)**	