

## 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
<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 <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Right <input type="checkbox"/> Left <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 <input type="checkbox"/> Right <input type="checkbox"/> Left <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

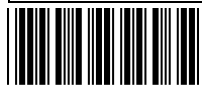
#### CT/MRI findings

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