Trillium Health Partners
Better Together

Regional Stroke Prevention Clinic Referral Form

THP Mississauga Hospital – 100 Queensway West
Mississauga, ON L5B 1B8 **Fax #: 905-848-7669**

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

The following information MUST be completed.
Incomplete forms will be returned.

☐ New Referral ☐ Post discharge Follow-up
To be done in SPC: ☐ Carotid Doppler
☐ TCD (at discretion of neurologist)

Most Recent Event: ☐<48h ☐48h-2 weeks ☐>2 weeks
Date of Most Recent Event: _____
Age: _____ BP: _____

Clinical Features: (check (✓) all that apply)
☐ Unilateral weakness: ☐ Face ☐ Arm ☐ Leg (☐ L ☐ R)
☐ Unilateral Sensory loss: ☐ Face ☐ Arm ☐ Leg (☐ L ☐ R)
☐ Speech disturbance: ☐ Aphasia ☐ Dysarthria
☐ Acute Vision Change:
☐ Monocular ☐ Hemifield ☐ Binocular Diplopia
☐ Ataxia
☐ Vertigo
☐ Carotid stenosis (☐ L ☐ R)
☐ Other: _____

Frequency of the Symptoms:
☐ Single episode: _____
☐ Persistent
☐ Recurrent or fluctuating

Vascular Risk Factors: (check (✓) all that apply)
☐ Hypertension
☐ Pregnancy
☐ Dyslipidemia
☐ Ischemic Heart Disease
☐ History of Atrial fibrillation
☐ Previous Stroke or TIA
☐ Previous known Carotid disease
☐ Peripheral Vascular Disease
☐ Current smoking/vaping
☐ Cancer
☐ Diabetes
☐ H/O Thrombosis
☐ Other

Diagnostic Investigations ordered or results attached. Do not delay referral if investigations not done.

Investigations	Location
☐ CT Head ☐ CTA (H & N)	
☐ MRI Head ☐ MRA (H &N)	
☐ Carotid Doppler US	
☐ ECG	
☐ ECHO ☐ TEE	
☐ Holter: ☐ 48 ☐ 72 ☐14 D ☐ 28 D	
☐Other:	

Consults ordered or consult reports attached.
☐None
☐ Vascular surgery or Neurosurgery for Carotid Stenosis
☐ Ophthalmology ☐ Other

Medications: (Attach List)
Medications initiated post event: ☐ None
☐ Aspirin
☐ Clopidogrel
☐ Anticoagulation
☐ Other:

Additional information:

Best Practices on Secondary Prevention of Stroke and Teaching for Referral Sources:

- https://www.strokebestpractices.ca/
- Review Signs of Stroke & when to call 911.
- Recommend refrain from driving until seen in SPC.
- TIA/Stroke education provided.

REFERRING PROVIDER: ☐ Family Physician ☐ ED Physician ☐ NP ☐ Specialist ☐ Inpatient Unit

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Hospital Affiliation _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Referral Date: _____