



Stroke Prevention Clinic
Referral Form

Phone: (613) 267-1500 ext. 4702
Fax: (613) 267-3449

Name: _____
Date of Birth: (dd/mm/yyyy) _____
Address: _____
City: _____
Postal Code: _____
Telephone # Home: _____
Work # or Alternate: _____
Family Physician: _____
Health Card # _____

Date of Event: _____ Date of Referral: _____
(dd/mm/yyyy) (dd/mm/yyyy)

Referring Physician or ER Physician _____ / _____
(Signature) (Please Print)

Referral Information:

- ☐ Motor Weakness: Left / Right _____
☐ Sensory loss: Left / Right / Face / Arm / Leg _____
☐ Speech Disturbance: _____
☐ Visual Loss: Left / Right / Bilateral / Amaurosis Fugax _____
☐ Vertigo: _____
☐ Duration symptoms: _____
☐ Other: _____

Risk Factors:

- ☐ Hypertension ☐ Atrial fibrillation ☐ Peripheral vascular disease
☐ Coronary artery disease ☐ Previous stroke or TIA ☐ Carotid stenosis
☐ Hyperlipidemia ☐ Diabetes Type 1 / Type 2 ☐ Other _____
☐ Family history heart disease or stroke _____
☐ Smoker: ☐ Never ☐ Current Pack Years _____

Allergies/Adverse Reactions: _____

Investigations (Indicate Date of Test)	Medications (Name/Dose)
☐ EKG	Antiplatelet:
☐ 48 Hour Monitor	Anticoagulant:
☐ CTA Scan - Head	Lipid Lowering Agent:
☐ Carotid Doppler (if CTA not available)	Other:
☐ Life Labs BW	