Regional Stroke Network
Réseau Régional des AVC
CHAMPLAIN

Name:
DOB:
OHIP#:
Telephone # (home):
Telephone # (work/other):
Address:

Stroke Prevention Clinic Consultation Form

Cornwall Community Hospital - McConnell site
840 McConnell Ave, Cornwall ON K6H 5S5
Phone: (613) 938-4240 ext 3118
Fax: (613) 938-5379

In order to provide appropriate care for your patient, we request that the following consult be filled in, *in its entirety*.
Incomplete forms will cause delay in processing.

Referred from: ☐ **Emergency** ☐ **Physician's Office** ☐ **Inpatient Unit** ☐ **Other Hospital** ☐ **Other** _____

Date: _____ **Family physician: Dr** _____

REASON FOR REFERRAL: ☐ **Transient Ischemic Attack (TIA)** ☐ **Risk Factor Management** ☐ **Post-Stroke Follow-up**

Comments:_____

_____

DATE of Transient Ischemic Attack /Minor Stroke Event: _____ (yyyy/mm/dd)

BP at time of event (if known): _____ **Current BP:**_____

SIGNS/SYMPTOMS suggesting TIA/Minor Stroke: (side R or L)				**Risk factors:**	
Unilateral motor deficit (s)	☐ **yes**	☐ **no**	**R or L**	☐ **Previous Stroke/TIA**	☐ **Pregnancy**
Unilateral numbness or tingling	☐ **yes**	☐ **no**	**R or L**	☐ **Hypertension**	☐ **Smoking**
Aphasia	☐ **yes**	☐ **no**		☐ **Atrial fibrillation**	☐ **Obesity**
Dysarthria	☐ **yes**	☐ **no**		☐ **Dyslipidemia**	☐ **Sedentary lifestyle**
Amaurosis fugax	☐ **yes**	☐ **no**	**R or L**	☐ **Diabetes**	☐ **Alcohol abuse**
Hemianopia	☐ **yes**	☐ **no**		☐ **CAD/PVD**	☐ **Drug abuse**
Other _____				☐ **Asymptomatic carotid stenosis**	

Duration of symptoms ☐ **<10 min** ☐ **10-59 min** ☐ **>60min** ☐ **Other** _____

Investigation (s): Check all that have been ordered. Indicate time and location of all tests (including those pending). Please include copies of any recent diagnostic/lab reports (<6 months)

☐ CT head *_____ ☐ Echocardiogram/TEE_____ ☐ Fasting glucose ☐ CBC

☐ Carotid Doppler _____ ☐ Holter monitor_____ ☐ Fasting lipid profile ☐ INR/PTT

☐ ECG_____ ☐ MRI/MRA_____ ☐ Electrolytes/Urea/Creatinine/LFTs/CK

- ***Please advise patient to bring a copy of the CT head on CD (if available).**
- **If a CT Head has not yet been ordered please send a completed/signed CT Head Requisition for the SPC to expedite.**

Medications Initiated: ☐ **Aggrenox** ☐ **Anti-coagulant:**_____ ☐ **ASA** ☐ **Plavix** ☐ **Statin**

Current Medication(s):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Referring Physician: _____/_____
(Print) (Signature)

Office telephone: _____ **Fax:** _____

Fax this completed form to 613-938-5379 with all available results. Upon receipt, referrals will be triaged accordingly.