

TIA/MINOR STROKE RAPID ASSESSMENT CLINIC REFERRAL – KAMLOOPS

Clinical Services Building, Level 2 Tel: 250-314-2100 Ext 18733
Royal Inland Hospital Fax: 250-314-2169

Patient Name (last) _____
(first) _____
DOB (dd/mm/yyyy) _____
PHN _____ MRN _____
Account/Visit # _____
IH USE ONLY

***Any patient requiring immediate assessment, contact Neurologist on-call through switchboard 250-374-5111**

PATIENT INFORMATION			
Name		Date of Birth (dd/mm/yyyy)	
Street Address		PHN	
		Phone	
City/Town		Cell Phone	
SYMPTOM ONSET DETAILS			
Date (dd/mm/yyyy)		Time: 24 hour clock (hh:mm)	
PRESENTING SYMPTOMS (Please check all that apply)			
<input type="checkbox"/> Speech disturbance <input type="checkbox"/> Motor weakness: <input type="checkbox"/> Face <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Visual disturbance <input type="checkbox"/> Sensory disturbance <input type="checkbox"/> Balance problems <input type="checkbox"/> Other: _____ Have symptoms resolved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Describe Patient Symptoms and Signs:	
REFERRING PROVIDER			
Date of Referral (dd/mm/yyyy)	Time (24 hour)	Name/Signature	Designation / College ID #
Referring Provider Location (City/Town)		<input type="checkbox"/> Family Physician <input type="checkbox"/> Specialist <input type="checkbox"/> ER Physician <input type="checkbox"/> NP <input type="checkbox"/> Other: _____	

ABCD ² Risk Screen for TIA Patients <i>(to be completed at the time of the referral)</i>		Points	
Age	<input type="checkbox"/> Equal to or greater than 60 years	1	Risk of Stroke within 2 days of TIA according to ABCD² is: Score 6–7 then risk is 8.1% 4–5 then risk is 4.1% 0–3 then risk is 1% <i>(Rothwell, P. et al. Lancet 2007; 369:283-92)</i>
Blood Pressure	<input type="checkbox"/> Systolic BP equal to or greater than 140 mmHg <input type="checkbox"/> Diastolic BP equal to or greater than 90 mmHg	1	
Clinical Features <i>(choose one)</i>	<input type="checkbox"/> Unilateral Weakness (with or without speech disturbance) <input type="checkbox"/> Speech deficit without weakness <input type="checkbox"/> Other	2 1 0	
Diabetes	<input type="checkbox"/>	1	
Duration	<input type="checkbox"/> 60 minutes or more <input type="checkbox"/> 10–59 minutes	2 1	
Score equal to or greater than 4 = High Risk			

ACKNOWLEDGEMENT OF REFERRAL (WILL BE COMPLETED BY TIA CLINIC STAFF)	
<input type="checkbox"/> Your patient is booked for their TIA clinic appointment on _____	<input type="checkbox"/> before we see your patient
<input type="checkbox"/> We require additional information _____	
<input type="checkbox"/> Your patient will not be seen at the TIA clinic. Reason _____	

****Please fax all supporting documentation including:**

- Completed Referral
- Current Medication and Allergy list
- Emergency Physician Record

Permanent part of the health record

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INFORMATION FOR REFERRING PHYSICIANS

The TIA/Minor Stroke Rapid Assessment Clinics are out-patient clinics that offer rapid access to screening, diagnostics, and assessment by a Neurologist.

- The clinic RN and Neurologist work together to screen and assess patients within 24 – 72 hours of referral, for the purpose of identifying the risk of a complete stroke outside of the Emergency Department.
- Patients will receive diagnostic screening for their cerebrovascular symptoms.
- If your patient is not seen in the clinic, you may be contacted by the Neurologist to review the case.

Clinic Hours are from 08:00 – 16:00, Monday to Friday.

- Closed on weekends and holidays.
- Referrals received outside of these hours are processed the next business day.

For any patient requiring immediate assessment, please contact the Neurologist on-call through switchboard 250-374-5111.

PATIENT DIRECTIONS

- Please give your patient the IH TIA Clinic Patient Information sheet Royal Printers # **828174**.
- Patients are to bring their current medications to the clinic.
- Patients are responsible for their own meals and regular medications while at the clinic.
- Patients should expect to be at the clinic for at least 4 – 8 hours.

PLEASE NOTE

- Patients must be independent, ambulatory and appropriate for an outpatient clinic visit.
- Patients are not to drive themselves – do not send patients by ambulance.

ABBREVIATIONS

ER	Emergency Room
NP	Nurse Practitioner
PHN	Personal Health Number
TIA	Transient Ischemic Attack