

STROKE PREVENTION CLINIC REFERRAL FORM

Owen Sound 519-376 -2121 Ext 2922

Date of Event: Durati	on of Symptoms:	_(min/hrs)
Signs/Symptoms eg. Unilateral weakness, numbness, speech disturbances vertigo, vision changes Side R L	Patient Legal Name] M
r L	Address: Postal Code: _	
	Phone #: Alt. Phone #: D.O.B: // Health Card #: Version Code: Exp.:	
	Medication(s) (include dose & frequency): Antiplatelets initiated/changed Anticoagulation initiated/changed	Yes No Yes No
Risk Factors:	- - - -	
□ Atherosclerosis □ Family Hx Stroke □ Obesity(BMI>25) □ Atrial Fibrillation □ Hyperlipidemia □ Previous stroke/ TIA □ Depression □ Hypertension □ Sleep apnea □ Diabetes □ Ischemic heart disease □ Tobacco use	Office Use Only	
Investigation(s) ☐ CTA (Head, Arch to Vertex) ☐ No- eGFR ≤ 30 or other ☐ CT Minus Head ☐ Carotid Doppler	Notes:	
Ø Echocardiogram Yes No Ø Electrocardiogram Yes No □ Holter 7day 14day No □ MRI / MRA Yes No	- - - -	
Laboratory Investigations (Please ensure requisition is completed) ☑ Na ☑ K ☑ Cl ☑ HDL ☑ eGFR ☑ CBC ☑ ALT/AST ☑ aPTT ☑ INR ☑ LDL ☑ Cr ☑ Hgb A1C ☑ Random BS ☑ Lipid profile	Triage Level:	
Billing #: Date: Signature of Authorized Provider : Print:	FAX COMPLETED FORM TO SCHEDUL 519-376-3952 SPC will complete electro diagnostic testing once	seen in clinic



Phone #:









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Revised October 2023