Brightshores Health System

STROKE PREVENTION CLINIC REFERRAL FORM

Owen Sound 519-376 -2121 Ext 2922

Date of Event: _____ **Duration of Symptoms:** _____ **(min/hrs)**

Signs/Symptoms eg. Unilateral weakness, numbness, speech disturbances vertigo, vision changes

Side

R ☐ L ☐

_____

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Risk Factors: (Select all that apply)

☐ Atherosclerosis	☐ Family Hx Stroke	☐ Obesity(BMI>25)
☐ Atrial Fibrillation	☐ Hyperlipidemia	☐ Previous stroke/ TIA
☐ Depression	☐ Hypertension	☐ Sleep apnea
☐ Diabetes	☐ Ischemic heart disease	☐ Tobacco use

Investigation(s)to be scheduled (All applicable requisitions are linked)

☐ CTA (Head, Arch to Vertex) ☐ Yes ☐ No

☐ eGFR 30 or less - Page High Priority CT Radiologist

☐ CT Minus Head

☐ Carotid Doppler

☐ Echocardiogram ☐ Yes ☐ No

☐ Electrocardiogram ☐ Yes ☐ No

☐ Holter ☐ 7 day ☐ 14 day ☐ 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	

_____

Patient Legal Name ☐ F ☐ M

Address: _____

City: _____ Postal Code: _____

Phone #: _____

Alt. Phone #: _____

D.O.B: _____ /_____ /_____ (YYYY/MM/DD)

Health Card #: _____

Version Code: _____ Exp.: _____

Medication(s) (include dose & frequency):

Antiplatelets initiated/changed ☐Yes ☐No

Anticoagulation initiated/changed ☐Yes ☐No

_____

_____

_____

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Office Use Only

Notes: _____

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Triage Level: _____

_____

Billing #: _____ Date: _____

Signature of Authorized Provider : _____

Print Provider Name: _____

Phone #: _____ Fax: _____

FAX COMPLETED FORM TO BRIGHTSHORES SPC:

519-378-1443

SPC will complete electro diagnostic testing once seen in clinic

INCLUDE SUPPORTING DOCUMENTATION

M-230 Revised Sept 2024

Brightshores Health System | HDH Hanover & District Hospital | South Bruce Grey Health Centre | Ontario South West Local Health Integration Network | Stroke Network Southwestern Ontario

* P H Y 0 0 2 *

Ontario
South West Local Health Integration Network

CT REQUISITION

Stroke Prevention Clinic

To be booked within 48hrs

Choosing Wisely Canada™
Go to www.swpca.ca for contact information to other SWLIN sites.

Fax completed requisition to:

Brightshores Health System Owen Sound Fax: 1-855-702-1968

PATIENT INFORMATION:

Surname: _____ First Name:_____ Middle Initial: _____ Gender: ☐ M ☐ F ☐ X

Date of Birth (YYYY-MM-DD): _____ Street Address: _____ Apt: _____

Health Card No. : _____ City: _____ Province: _____ Postal Code: _____

Version Code: _____ Research or 3rd Party No.: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED

WSIB: ☐ Y ☐ N _____ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER: _____

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

Y N Please check the following: ***If yes to any of the risk factors please draw creatinine levels*

- ☐ ☐ Allergic to radiographic contrast
- ☐ ☐ Pregnant _____weeks
- ☐ ☐ Heparin Flush Ordered
- ☐ ☐ Power PICC
- ☐ ☐ CT Porta Cath
- ☐ ☐ History of Cancer

Precautions

☐ TB ☐ MRSA
☐ VRE ☐ Shingles

Y N Contrast Risk Factors:

- ☐ ☐ Diabetic
- ☐ ☐ On dialysis
- ☐ ☐ History of impaired renal function or Nephrectomy
- ☐ ☐ Patient > 70 yrs old
- ☐ ☐ On any diabetic medications: _____
- ☐ ☐ Hypertension
- ☐ ☐ Medications/conditions predisposing to nephrotoxicity
- ☐ ☐ Other: _____

- ☐ Y ☐ N Related Surgery
- ☐ Y ☐ N Urgent
- ☐ Y ☐ N Routine
- ☐ Y ☐ N Timed _____
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Staging / Follow-up

_____ Timing of above

Please attach previous imaging and reports (ie. ECG)

Serum Creatinine (must be drawn within the past 6 months)

Result:_____

eGFR:_____

Sample date:_____

Height: cm/in._____

Weight: kg/lbs._____

REFERRING PHYSICIAN:

Name_____ Address:_____

City:_____ Postal Code:_____ Tel:_____ FAX:_____

Physician's Signature:_____ Billing #:_____

Copy to:_____ Date:_____

EXAMINATIONS / PROTOCOLS

- ☐ CTA Carotid COW contraindicates if eGFR 30 or less
- ☐ CT Head: Unenhanced Only
- ☐ Other _____
- ☐ P2 - within 2 business days
- ☐ P3 - within 10 business days

Clinical Information (*Required*)

FOR BOOKING STAFF

Prep Information

- ☐ No prep required
- ☐ Clear fluids only 4 hours prior
- ☐ Drink 1 bottle of water en route & do not void
- ☐ Patient may be here 2+ hours
- ☐ Bring list of medications
- ☐ Start IV # _____
- ☐ Consent obtained by MRP

Appointment Date:_____

Arrival Time:_____