WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

R E F F O R M

PRINT

RESET

Name: _____

Date of Birth: _____

Phone #: _____

HCN: _____

URGENT TIA CLINIC REFERRAL FORM

Phone: **519-254-5577** Ext: **33665** FAX: **519-255-2285**

** REFERRING PHYSICIANS **MUST** SPEAK WITH THE NEUROLOGIST ON CALL **

** PLEASE FAX ALL RELEVANT DIAGNOSTIC/LAB REPORTS **

SIGNS / SYMPTOMS	SIDE (RIGHT/LEFT)
F-ACE (DROOP)	
A-RMS (WEAK)	
S-PEECH (DIFFICULTY)	
T-IME (LENGTH)	
TRANSIENT PAINLESS BLINDNESS	

MEDICATIONS

LOADING DOSE	MAINTENANCE DOSE
☐ ASA 81 mg PO	☐ ASA 81 mg PO daily
☐ ASA 160 mg PO	☐ ASA 325 mg PO daily
☐ Clopidogrel 300 mg PO	☐ Clopidogrel 75 mg PO daily
☐ Clopidogrel 600 mg PO	☐ ASA 81 mg PO & Clopidogrel 75 mg PO daily

DUAL ANTIPLATELET THERAPY

For very high risk patients ($ABCD^2$ score greater than 4) with TIA or minor stroke of non-cardioembolic origin (NIHSS 0-3); loading dose followed by dual antiplatelet therapy should be started, after brain imaging.

☐ ASA 81 mg PO & Clopidogrel 75 mg PO x 21-30 days. Resume monotherapy indefinitely.

Box 6A:

Canadian Stroke Best Practices

VERY HIGH Risk for Recurrent Stroke (Symptom onset within last 48 Hours): Patients who present **within 48 hours** of a suspected transient ischemic attack or non-disabling ischemic stroke with the following symptoms are **considered at highest risk** of first or recurrent stroke: transient, fluctuating or persistent unilateral weakness (face, arm and/or leg); transient, fluctuating or persistent *language/speech disturbance; and/or* fluctuating or persistent symptoms *without motor weakness or language/speech disturbance* (e.g. hemibody sensory symptoms, monocular vision loss, hemifield vision loss, +/- other symptoms suggestive of posterior circulation stroke such as binocular diplopia, dysarthria, dysphagia, ataxia).

For additional risk stratification, refer to Section Two of this module.

CSBPR; Sixth Edition; May 16, 2018. Taken from www.strokebestpractices.ca on May 23, 2019

Comments (Event Time/Duration/Date):

Referring Physician Name (Print) _____ Neurologist Contacted _____

Referring Physician (Signature) _____ Date _____