London Health Sciences Centre

URGENT TIA CLINIC INTAKE FORM

Referral information (booking clerk to complete this section and enter into database)

DATE OF REFERRAL:_____ ID: _____

NAME:_____ PIN:_____
FIRST NAME ***LAST NAME***

DATE OF BIRTH:_____-____- ____ DATE OF EVENT: _____

REFERRING MD/NP:_____ REFERRAL SOURCE:_____

Previously seen in UTIA clinic: If yes Doctor seen:_____Year:_____

Other Neurologist: If yes Doctor seen:_____Year:_____

Out of Catchment: If yes Location: _____

Patient Admitted currently ☐

ASA ☐

_____

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_____

Directions for clerk_____

_____

_____

_____

_____

Phone call dates and reason

DATE OF CLINIC:_____TIME:_____ PHYSICIAN:_____ ☐ Confirmed

REASON FOR DELAY (>24hrs from referral): ☐Pt declined ☐ No clinic space ☐ Other_____

Accepted ☐