London Health Sciences Centre

URGENT TIA CLINIC

INCOMPLETE OR ILLEGIBLE FORMS MAY RESULT IN DELAYS

Department of Clinical Neurosciences
University Hospital
Tel: 519-663-3674
Fax: 519-663-3140

☐ **I request Carotid Ultrasound Monitoring if indicated.**

Patient's Name: ______________________ **Health Card #:** ______________

Address: ____

____

Telephone: ______________________

Date of Event (TIA or MINOR STROKE): ____________ **Date of Birth:** ____________ **Age:** ______
YYYY / MM / DD YYYY / MM / DD

Signs/Symptoms:		Side (R/L)	Duration (mins)
Unilateral motor deficit(s)	☐Yes ☐No	______	______
Unilateral numbness/tingling	☐Yes ☐No	______	______
Aphasia	☐Yes ☐No		______
Dysarthria	☐Yes ☐No		______
Amaurosis Fugax	☐Yes ☐No	______	______
Hemianopia	☐Yes ☐No	______	______
Vertigo*	☐Yes ☐No		______
Headache	☐Yes ☐No	______	______

*Must be accompanied by one other symptom (e.g., dysarthria, diplopia, ataxia)

Risk Factors:
- ☐ Atherosclerosis
- ☐ Hypertension
- ☐ Ischemic Heart Disease
- ☐ Hyperlipidemia
- ☐ Atrial Fibrillation
- ☐ Diabetes
- ☐ Previous Stroke or TIA
- ☐ Tobacco Use
- ☐ Sleep Apnea
- ☐ Family Hx Stroke
- ☐ Depression

History/Comments: ____

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Investigation(s) (most recent):			Date (YYYY / MM / DD):
Carotid Ultrasound	☐ Yes	☐ No	____________
CT Head	☐ Yes	☐ No	____________
Echocardiogram	☐ Yes	☐ No	____________
Electrocardiogram	☐ Yes	☐ No	____________
Holter Monitor	☐ Yes	☐ No	____________
MRI/MRA	☐ Yes	☐ No	____________
Bloodwork	☐ Yes	☐ No	____________

Medication(s) (include dose & frequency):

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Referring MD and Referring No.: ____________________________

Tel: ______________________ **FAX:** ______________________

Please fax this form and copies of all investigation(s) to: URGENT TIA CLINIC 519-663-3140

Revised (2016/06/20)