London Health Sciences Centre

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

URGENT TIA AND CAROTID CLINIC FORM

Reason for Referral: ☐ TIA Clinic ☐ Carotid Revascularization

Patient's Name: _____ **HCN:** _____

Contact Info:

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

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	_____	_____
Hemianopsia	☐ Yes	☐ No	_____	_____
Vertigo*	☐ Yes	☐ No		_____
Headache	☐ Yes	☐ No	_____	_____

Other _____

*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:

Investigation(s) (most recent):			**Date (YYYY/MM/DD):**
Carotid Ultrasound	☐ Yes	☐ No	_____
CTA Head and Neck	☐ Yes	☐ No	_____
Echocardiogram	☐ Yes	☐ No	_____
Electrocardiogram	☐ Yes	☐ No	_____
Holter Monitor	☐ Yes	☐ No	_____
MRI/MRA	☐ Yes	☐ No	_____
Bloodwork	☐ Yes	☐ No	_____

Medication(s) (include dose & frequency):

Antiplatelets initiated/changed ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

Referring MD and Referring No.: _____

Tel: _____ **Fax:** _____

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

INCOMPLETE OR ILLEGIBLE FORMS MAY RESULT IN DELAYS