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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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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Risk Factors:

☐ 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) **Date** (YYYY/MM/DD)

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

☐ No- eGFR ≤ 30 or other contraindication

☐ CT Minus Head

☐ Carotid Doppler

☒ Echocardiogram ☐ Yes ☐ No _____

☒ Electrocardiogram ☐ Yes ☐ No _____

☐ Holter ☐ 7day ☐ 14day ☐ No _____

☐ MRI / MRA ☐ Yes ☐ 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	

Office Use Only

Notes: _____

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Triage Level: _____

_____

Billing #: _____ Date: _____

Signature of Authorized Provider : _____

Print: _____

Phone #: _____

FAX COMPLETED FORM TO SCHEDULING:

519-376-3952

SPC will complete electro diagnostic testing once seen in clinic

INCLUDE SUPPORTING DOCUMENTATION

M-230 Revised March 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 *