

**URGENT TIA CLINIC REFERRAL**

(No appointment will be given without this information)

**Patient's Name:** \_\_\_\_\_ **Health Card #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Date of Event (TIA or MINOR STROKE):** \_\_\_\_\_  
YYYY / MM / DD

**Date of Birth:** \_\_\_\_\_  
YYYY / MM / DD

**Signs/Symptoms:** (Side R or L)

Unilateral motor deficit(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Unilateral numbness/tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Aphasia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Dysarthria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Amaurosis Fugax	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hemianopia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vertigo*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

<b>ABCD<sup>2</sup> Score</b>	
<input type="checkbox"/> Age ≥60 years	(1 point)
<input type="checkbox"/> Systolic blood pressure ≥ 140 mm Hg	(1 point)
<b>and/or</b> Diastolic blood pressure ≥ 90 mm Hg	
<input type="checkbox"/> Unilateral weakness	(2 points)
<input type="checkbox"/> Speech disturbance without weakness	(1 point)
<input type="checkbox"/> TIA duration ≥ 60 minutes	(2 points)
<input type="checkbox"/> TIA duration 10 - 59 minutes	(1 point)
<input type="checkbox"/> Diabetes	(1 point)
Total Score: _____	

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

**Comments:** \_\_\_\_\_

<b>Investigation(s) (most recent):</b>	<b>Date (YYYY / MM / DD):</b>	<b>Medication(s) (include dose &amp; frequency):</b>
Carotid Ultrasound <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
CT Head <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Echocardiogram <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Electrocardiogram <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Holter Monitor <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
MRI/MRA <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
CBC <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
INR/PTT <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Serum Glucose <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Serum Lipids <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**Was an outpatient MRI ordered as per the TIA study protocol?"**  Yes  No

**Referring MD and Referring No.:** \_\_\_\_\_

**Tel:** \_\_\_\_\_ **FAX:** \_\_\_\_\_