

**Quinte Health Care
Stroke Prevention Clinic
Referral Form**

Belleville General Hospital-WCA2
265 Dundas Street East
Belleville, ON K8N 3A9
Telephone: (613) 969-7400 Ext 2871

Fax: (613) 961-2544

Appropriate referrals for the Clinic include those patients who are at an increased risk of stroke:

1. Patients with recent history Transient Ischemic Attack or stroke
2. Patients who have important risk factors for stroke and require treatment and/or counselling.

Unit #:
Name:
Date of Birth: *(dd mm yyyy)*
Address:
City:
Postal Code:
Telephone # Home:
Work # or Alternate:
Family Physician:
Health Card #

Date of Transient Ischemic Attack (TIA)/event: _____ Date of Referral: _____
(dd mm yyyy) *(dd mm yyyy)*

Referring Physician or Attending ER Physician _____ / _____
(Signature) (Please Print)

Referral Information:

- Motor Weakness: Left / Right _____
- Sensory loss: Left / Right _____
- Speech Disturbance: _____
- Visual Loss: Left / Right / Bilateral _____
- Other: _____
- Duration symptoms: _____

RISK FACTORS:

- | | | |
|---|---|--|
| <input type="checkbox"/> hypertension | <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> previous stroke or TIA | <input type="checkbox"/> carotid stenosis |
| <input type="checkbox"/> smoking history | <input type="checkbox"/> hyperlipidemia | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> family history heart disease or stroke | <input type="checkbox"/> diabetes | _____ |

Medication: Antiplatelet: _____ Anticoagulant: _____

Allergies/Adverse Reactions: _____

Labwork*:

If ordered/completed **in past 2 weeks**, please forward CBC, INR, Electrolytes, Urea, Creatinine, TSH
If completed **in past 6 months**, please forward Fasting Lipids, Fasting Glucose, HgA1C

***If not available, Stroke Prevention Clinic will order on receipt of this referral**