Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required
Please ensure correct contact information is included
Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN
Phone number(s)
Alternate contact person *(name, phone)*

Central Alberta - TIA & Stroke Clinic Outpatient Referral

Fax this completed form and related records to desired location below.

☐ Red Deer Regional Hospital	Fax 403-343-4531	Phone 403-406-5508
☐ Camrose St. Mary's Hospital	Fax 780-679-3116	Phone 780-679-3112

Please note: Acute stroke and high risk TIA (presenting within 48h of symptom onset, with motor or speech symptoms) **are medical emergencies**. Contact the neurologist on call or the TIA Hotline via RAAPID for your area.

- Northern Alberta including Red Deer - **RAAPID North 1-800-282-9911**
- Areas South of Red Deer - **RAAPID South 1-800-661-1700**

■ All fields must be completed. Incomplete forms will result in assessment delay. All referrals are triaged for acuity and appropriateness

Referring Physician	Date of Referral *(yyyy-Mon-dd)*	Time of Referral *(hh:mm)*

Referral Source
☐ Emergency Department
☐ Physician Office
☐ Early Supported Discharge
☐ Other _____

Family Physician

Event history

Have symptoms resolved ? ☐ Yes ▶ ☐ No ***If no, consider ED and/or Urgent neurology consultation.***

Date of Event or Onset of Symptoms *(yyyy-Mon-dd)*	**Duration of Symptoms** _____ Hours _____ Minutes

When did Symptoms begin *(as of referral date)*
☐ Within past 48 hours
☐ Within 48 hours to 2 weeks
☐ Greater than 2 weeks ago

Presenting Signs/Symptoms *(check/circle all that apply)*
☐ Unilateral motor deficit (face, arm and/or leg)
☐ Hemibody sensory loss
☐ Speech disturbance ☐ Dysarthria ☐ Aphasia
☐ Visual disturbance ☐ Monocular ☐ Field loss ☐ Diplopia
☐ Loss of coordination

Contact local neurology or RAAPID if
■ Symptoms onset within the past 48 hours
■ **Speech/motor symptoms within the past 2 weeks**

Note: Isolated syncope or dizziness is rarely a TIA and may not require Stroke Prevention Clinic referral; consider referral to general neurology and/or cardiology

Additional information/investigation if available:

Current Antiplatelet/Anticoagulant Therapy
☐ ASA ☐ dipyridamole-ASA (AGGRENOX) ☐ clopidogrel (PLAVIX) ☐ warfarin (COUMADIN)
☐ DOAC (Direct Oral Anticoagulant) ☐ Other _____

Heart & Stroke Foundation™ - Canadian Stroke Best Practice Recommendations

Taking Action in Stroke Prevention
A Quick Response Guide

Risk for Recurrent Stroke – Patients Presenting with Transient Ischemic Attack or Non-Disabling Stroke
Triage Patient Based on Time Since Onset of Stroke symptoms and Clinical Presentation

Highest Risk *(Most Urgent)*	Higher Risk	Increased Risk		Lower Risk
Symptom Onset – Within 48 Hours		**Symptom Onsent – 48 Hours to 2 Weeks**		
Symptoms: Transient, fluctuating or persistent unilateral motor weakness (face, arm and/or leg), or speech disturbance.	**Symptoms:** Transient, fluctuating or persistent symptoms such as hemibody sensory loss, acute monocular visual loss, binocular diplopia, hemivisual loss, or dysmetria; ***without motor weakness or speech disturbance.***	**Symptoms:** Transient, fluctuating or persistent unilateral weakness or speech disturbance.	**Symptoms:** Transient, fluctuating or persistent symptoms such as hemibody sensory loss, acute monocular visual loss, binocular diplopia, hemivisual loss, or dysmetria; ***without motor weakness or speech disturbance.***	**Symptoms:** Patient who presents more than 2 weeks from symptom onset. Patient experiencing atypical sensory symptoms which do not fit an anatomical distribution to suggest stroke or TIA (such as patchy numbness and/or tingling).
Immediate Actions: 1. **Immediate** transport via EMS to the closest emergency department with capacity for advanced stroke care (brain imaging, tPA capability). 2. **Initial Investigations:** a. **Urgent** brain imaging (CT or MRI) and non-invasive vascular imaging, including intracranial and extracranial vessels where possible. b. 12 lead ECG to assess for atrial fibrillation. c. Initiate antiplatelet therapy if no blood on CT scan.	**Immediate Actions:** 1. Refer for **same-day** assessment at the closest stroke prevention clinic or emergency department with capacity for advanced stroke care (brain imaging, possibly tPA capacity). 2. **Initial Investigations:** a. **Same-day** brain imaging (CT or MRI) and non-invasive vascular imaging. b. 12 lead ECG to assess for atrial fibrillation. c. Initiate antiplatelet therapy if no blood on CT scan.	**Immediate Actions:** 1. **Within 24 hours** of first contact with healthcare system: comprehensive clinical evaluation and investigations, including brain and vascular imaging, by a healthcare professional with stroke expertise. 2. Initiate antiplatelet therapy if no blood on CT scan	**Immediate Actions:** 1. **Within 2 weeks** of first contact with the healthcare system: comprehensive clinical evaluation and investigations, including brain and vascular imaging, by a healthcare professional stroke expertise. 2. Initiate antiplatelet therapy if no blood on CT scan.	**Immediate Actions:** 1. **Within 1 month** of first contact with the healthcare system: should be seen by a healthcare professional with expertise in neurology or stroke for evaluation as soon as possible.

Additional Clinical Investigation

1. Brain imaging (CT or MRI) and non-invasive vascular imaging of the intracranial and extracranial vasculature using CT angiography at the time of brain CT, or alternatively carotid ultrasound or MR angiography if CTA not available.
2. Laboratory investigations: hematology (complete blood count), electrolytes, coagulation (aPTT, INR), renal function (creatinine, e-glomerular filtration rate), fasting lipid profile, fasting glucose level and A1C, and ALT.
3. ECG to assess baseline cardiac rhythm and presence of structural heart disease.
4. Prolonged ECG monitoring (Holter monitoring, loop recorder, event monitoring as available) where a cardioembolic mechanism is possible and/or the stroke mechanism has not been identified.

Please refer to the Hyperacute Module and the Prevention of Stroke Module for specific management recommendations based on results of the investigations above. strokebestpractices.ca