Reason for Referral: Please complete all sections of this referral:
☐ TIA  ☐ Stroke  ☐ Query TIA/Stroke  ☐ Carotid Stenosis  ☐ Significant Stroke Risk Factors

Date & Time of Most Recent Event:
_______________________________________________________

Duration & Frequency of Symptoms:
______________________________________________________

Clinical Features:

Motor: (Weakness)
☐ Face  ☐ Arm  ☐ Leg  ☐ Ataxia

Sensory: (Numbness)
☐ Face  ☐ Arm  ☐ Leg

Speech:
☐ Dysarthria  ☐ Aphasia

Visual:
☐ Monocular  ☐ Hemifield  ☐ Binocular Diplopia

Other:
________________________________

Risk Factors:
☐ Hypertension  ☐ Dyslipidemia  ☐ Diabetes
☐ Ischemic Heart Disease  ☐ History of Atrial Fibrillation  ☐ Previous Stroke or TIA
☐ Previous known Carotid Disease  ☐ Peripheral Vascular Disease  ☐ Smoking/Vaping
☐ Alcohol Abuse  ☐ Drug Abuse  ☐ Other: ___________________________

Suggested Diagnostic Investigations ordered or results attached (do not delay referral if investigations not done):

☐ CTA (head & neck)  ☐ MRA (head & neck)  ☐ 12 lead ECG
☐ CT (head)  ☐ MRI (head)  ☐ Bloodwork (CBC, PTT/INR, lytes, Cr, Glu, LFTs, Trop, HbA1C, TSH, lipid profile)
☐ Carotid Doppler  ☐ Echocardiogram  ☐ Other
☐ Ultrasound  ☐ 48 hr Holter Monitor

Consult reports attached:
☐ Vascular Surgery or Neurosurgery for Carotid Stenosis  ☐ Other: __________________________________________________________________

Medications (Attach List), Medication initiated post event:

☐ Antiplatelet therapy:

☐ Anticoagulant:

☐ Other:

Signature of Referring Provider: ____________________________________________