**STROKE AND TIA REFERRAL FORM**

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| **PLEASE INDICATE BELOW WHICH STROKE MEDICINE SERVICE YOU WISH TO ACCESS** | | | | | |
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|  | **HIGH RISK TIA**  (Event occurred < 1 week) | | | **LOWER RISK TIA**  (Event occurred > 1 week ago) | |
| Transient Ischaemic Attack Clinic Referral | 🞎 | | | 🞎 | |
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| Stroke Medicine Clinic Referral | 🞎 | | | *To see within 6 weeks* | |
| Advice and Guidance from Stroke Medicine Team | 🞎 | | | *Reply within 48 hours* | |
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| **CONTACT US FIRST FOR TIA REFERRALS** | | | | | |
| PLEASE CALL THROUGH TO THE **STROKE NURSE PRACTITIONNER** ON **07769 932 342 / 07971 717 588**  or the **ON-CALL STROKE CONSULTANT** FOR **ALL TIA** REFERRALS FIRST SO APPROPRIATE PATHWAY / TRIAGE CAN OCCUR  **INCOMPLETE FORMS WILL BE RETURNED** | | | | | |
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| **PATIENT DETAILS** | |  | **REFERRER DETAILS** | | |
| Name:  Address:  Postcode:  DOB:  NHS Number:  Contact Number:  Back-up Contact No: | |  | Name:  Address:  Postcode:  Telephone Number:  Email address:  Please supply contact details in case of need for more information to triage or discuss management | | |
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| **ONSET: TIME: DATE:** | |  | **REFERRAL: TIME: DATE:** | | |
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| **PLEASE GIVE A DESCRIPTION OF THE EVENT AND THE QUESTION BEING ASKED** | | | | | |
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| **RELEVANT MEDICAL HISTORY AND MEDICATION** | | | | | |
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| **STROKE / TIA SYMPTOMS** | |  | **RISK FACTORS** | | |
| Unilateral facial weakness YES  NO  Unilateral arm YES  NO  Unilateral leg weakness YES  NO  Unilateral sensory loss YES  NO  Dysphasia YES  NO  Visual loss in one eye YES  NO  Homonymous hemianopia YES  NO  Diplopia YES  NO  Ataxia YES  NO | | Atrial Fibrillation YES  NO  Hypertension YES  NO  Ischaemic Heart Disease YES  NO  Smoker YES  NO  Diabetes Mellitus YES  NO  Congestive Cardiac Failure YES  NO  Previous Stroke / TIA YES  NO  Peripheral Vascular Disease YES  NO  Hyperlipidaemia YES  NO  Anticoagulation YES  NO | | |
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| **NON-STROKE / NON-TIA SYMPTOMS** | |  | **INVESTIGATIONS DONE** | | |
| Bilateral central visual loss YES  NO  Visual aura YES  NO  Headache YES  NO  Amnesia YES  NO  Loss of consciousness YES  NO  Tingling and numbness YES  NO  Vertigo YES  NO | |  | FBC  U&Es  Cholesterol  Glucose  ESR  ECG | | RESULTS |
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| **ADVICE FOR REFERRER AND PATIENT** | | | | | |
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| **TIA REFERRALS ONLY** | |  | **FURTHER INFORMATION** | | |
| * Give 300mg aspirin now and continue daily until seen * Clopidogrel 75mg if aspirin allergic and continue daily * Give atorvastatin 20-80mg if no contraindications * Pulse check to confirm sinus rhythm * Do not drive until seen in TIA clinic * Call 999 if symptoms recur * Ask any witness to accompany patient to clinic | | * Ensure you have completed ONSET TIME & DATE * For QEHB send to [QEHB.stroke@uhb.nhs.uk](mailto:QEHB.stroke@uhb.nhs.uk) * For all HGS sites to [HGS.stroke@uhb.nhs.uk](mailto:HGS.stroke@uhb.nhs.uk) * Please expect a follow-up call as more information is often required if a TIA / Stroke mimic is suspected * Expect an appointment within the next seven days or sooner at the **LOCAL STROKE CENTRE** for TIAs | | |
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| **OTHER REFERRALS** | | | | | |
| **UNILATERAL VISUAL LOSS: SIMULTANEOUS REFERRAL TO OPTHALMOLOGY (BMEC) AND**  **UHB TIA CLINIC IS ADVISABLE**  **Syncope, Blackouts and/or Falls:** ConsiderGeriatric Medicine Clinic or Cardiology Clinic Referral  **Seizure-Like Episode:** ConsiderNeurology Clinic / First Fit Referral  **Progressive Memory Loss:** Consider Memory Clinic (Via Memory Service At Moseley Hall) | | | | | |
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| **HIGH RISK TIA PATIENTS** | | | | | |
| The majority of TIA patients are now considered high risk and will be seen soon after referral (often <24 hours)  TIA patients that may require admissions include but are not limited to:  **PERSISTENT NEUROLOGICAL SYMPTOMS**  **FLUCTUATING SYMPTOMS**  **DIFFICULTY SWALLOWING**  **PATIENTS ON FULL ANTICOAGULATION (WARFARIN / DOAC)**  **BLOOD PRESSURE >180/100**  **CRESCENDO TIAS**  **POSSIBLE DISSECTION CAUSING TIA (FACIAL / NECK PAIN WITH TIA SYMPTOMS)** | | | | | |
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| **OTHER INFORMATION** | | | | | |
| Patients with a suspected acute stroke with ongoing residual symptoms should be conveyed by ambulance to their nearest Hyper-Acute Stroke Unit via 999. This form is for urgent and non-urgent stroke **OUT-PATIENTS REQUESTS** only within UHB.  Please include relevant information from GP records / external hospital records / BMEC records | | | | | |