Perth and Smiths Falls District Hospital

The Vascular Protection Clinic
Referral Form
Phone: (613) 267-1500 ext. 4263
Fax: (613) 267-3449

Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone: _____

Alternate or work#: _____

Family Physician: _____

HIN:_____ DOB: _____

Z# _____

****Please ensure that all diagnostic testing is initiated at the time of referral.****

Referring Physician _____/_____
(signature) (print please)

Physician Referring No: _____ Date: _____

****

Onset of event: (date) _____ **Duration of event**:_____

SIGNS AND SYMPTOMS OF TIA/CVA: (please specify)
" Sensory " Motor " Amaurosis Fugax
" Right " Left " Face " Arm " Leg
" Vertigo " Other:_____

VASCULAR RISK FACTORS:
" Age " Weight " Sedentary
" Smoker " Never " Current Pack Years _____
" HTN " Cholesterol " DM
" Family History " Hx TIA/CVA " A-Fib " Known carotid stenosis

INVESTIGATIONS (Indicate date of test)
" EKG _____
" 48 Hour Holter _____
" Carotid Dopplers _____
" CT Scan – Head _____
" Echocardiogram _____

MEDICATIONS (Name/dose)
Antiplatelet: _____
Lipid Lowering Agent: _____
Ace Inhibitor: _____
Other: _____
Allergies: _____

RECOMMENDATIONS:
1. Refer all patients with TIA/CVA to the Vascular Protection Clinic.
2. Consider admitting cresendo TIAs; persisting deficits of new onset.
3. Start or change antiplatelet therapy if complete resolution of event (or if negataive CT scan)
4. Carotid dopplers (or CT-A) within 24 hours of an anterior circulation event.
5. Consider ENT referral for vertigo without associated neurologic signs and symptoms
6. Consider patients without an event but at high risk i.e. if $\geq$ 3 risk factors, or significantly poor control of 1 or more risk factors, for referral re primary prevention.