Name:

Address:

City: Postal Code:

 Telephone:

**The Vascular Protection Clinic**

**Referral Form**

**Phone: (613) 267-1500 ext. 4263**

**Fax: (613) 267-3449**

 Alternate or work#:

 Family Physician:

 HIN: DOB:

Z#

**\*\*ALL diagnostic testing MUST be initiated at the time of referral\*\***

**\*\*FAX all referrals directly to appropriate departments \*\***

Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (signature) (print please)

Physician Referring No: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office contact info: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Onset of event**: (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Duration of event**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Event Description:**

***Please attach clinic note, medical history and/or ER record for more info.*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Investigations** (Indicate date of test) **Medications** (Name/dose)

 EKG Antiplatelet:

 48 Hour Holter Lipid Lowering Agent:

 CTA Scan – Head Ace Inhibitor:

 Echocardiogram Other:

 Carotid Doppler (If CTA not available) Allergies:

 Outpatient FASTING BW \_\_\_\_\_\_

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 > 3 risk factors, or significantly poor control of 1 or more risk factors, for referral re primary prevention.

**Signs and symptoms of TIA/CVA**: (please specify)

 Sensory Motor Amaurosis Fugax

 Right Left Face Arm Leg

 Vertigo Other:\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Vascular Risk Factors**:

 Age HTN Hx TIA/CVA

 Weight Cholesterol A-Fib

 Sedentary DM Known carotid stenosis

 Family History

 Smoker Never Current Pack Years