**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 | | | 🞎 | | | 🞎 | | |
|  | | |  | | |  | | |
| Stroke Medicine Clinic Referral | | | 🞎 | | | *To see within 6 weeks* | | |
| Advice and Guidance from Stroke Medicine Team | | | 🞎 | | | *Reply within 48 hours* | | |
| Stroke Nurse Practitioner Clinic | | | 🞎 | | | *To see within 6 weeks* | | |
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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  Unilateral arm  Unilateral leg weakness  Unilateral sensory loss  Dysphasia  Visual loss in one eye  Homonymous hemianopia  Diplopia  Ataxia | | YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO | | Atrial Fibrillation  Hypertension  Ischaemic Heart Disease  Smoker  Diabetes Mellitus  Congestive Cardiac Failure  Previous Stroke / TIA  Peripheral Vascular Disease  Hyperlipidaemia  Anticoagulation | | | YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO |
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| **NON-STROKE / NON-TIA SYMPTOMS** | | | |  | **INVESTIGATIONS DONE** | | | |
| Bilateral central visual loss  Visual aura  Headache  Amnesia  Loss of consciousness  Tingling and numbness  Vertigo | YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  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 * Send this document to [TIAFaxGateway@uhb.nhs.uk](mailto:TIAFaxGateway@uhb.nhs.uk) * Please expect a follow-up call as often more information required especially if a TIA / Stroke mimic is strongly 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 | | | | | | | | |