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| **Department of Stroke Medicine**T.I.A. Clinic REFERRAL FORM | **Based at Hull Royal Infirmary and Castle Hill Hospital** |
| **NHS Number:****Patient name:****Date of Birth:****Contact number(s):** | Consultant or General Practitioner responsible for the Patient**Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_** **GMC: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_**To ensure patients continued care is maintained |
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| **Suspected TIA**PLEASE, NOTE THAT THE FOLLOWING CLINICAL FEATURES, WHEN OCCURRING ALONE, ARE UNLIKELY TO BE A MANIFESTATION OF A TIA: GENERALISED WEAKNESS, CONFUSION, AMNESIA,BEHAVIOURAL DISTURBANCE, SEIZURE, HEADACHE, LIGHT-HEADEDNESS, FAINTING, BLURRED VISION, SCINTILLATING SCOTOMA, ISOLATED DIPLOPIA, TINNITUS, DYSPHAGIA. |
| **Clinical Presentation** (please tick or circle as appropriate) | **Date of symptom onset**: \_ \_ / \_ \_ / \_ \_ \_ \_ |
| 🞏 R L FACE🞏 R L ARM🞏 R L LEG | } | WEAKNESS |  | 🞏 R L AMAUROSIS FUGAX🞏 R L HOMONYMOUS HEMIANOPIA🞏 R L ARM / LEG INCOORDINATION🞏 ATAXIC STANCE / GAIT🞏 DYSARTHRIA🞏 EXPRESSIVE/ RECEPTIVE DYSPHASIA |
| 🞏 R L FACE🞏 R L ARM🞏 R L LEG | } | NUMBNESS /PINS & NEEDLES |  |
| Brief description of presenting complaint |
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| **Stroke Risk Assessment** |
| 🞏 **Recurrence of symptoms: No \_ \_ \_** | 🞏 **Anticoagulation** | 🞏 **Atrial fibrillation or atrial flutter** |
| **ABCD2 Score** (please, add the individual scores that apply to patient up to a maximum score of 7 points) |
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| ●Age | **≥ 60 y old** | **1** |  | ●Duration | { | **≥ 60 minutes** | **2** |
| ●Blood pressure**(1 point maximum)** | { | **Systolic BP** | **≥ 140 mm Hg** | **1** |  | **10-** **59 minutes** | **1** |
| **Diastolic BP** | **≥ 90 mm Hg** |  | ●Diabetes Mellitus | **1** |
| ●Clinical features**(2 points maximum)** | { | **Unilateral weakness** | **2** |  | **Total:** |  |
| **Speech disturbance (no weakness)** | **1** |  |
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| **If TIA is probable, please prescribe Aspirin 300 mg stat and 75 mg once daily (unless on anticoagulants)****For patients allergic or intolerant to Aspirin, please prescribe Clopidogrel 75 mg once daily** |
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| **Low Risk Patient**Assessment within 7 days**●ABCD2 Score of** [**0 - 3**]  |  | **High Risk Patient** Assessment within 24 hours |
| **●ABCD2 Score of** [**4 - 7**]**●Patient on Anticoagulation** | **●Recurrent symptoms within 6 weeks****●Patient in atrial fibrillation or atrial flutter** |
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| **Please, advise not to** **drive for 4 weeks** |  | **If symptoms are recurrent, please advise not to drive for** **3 months after the last event**  |
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| From **Monday to Friday, 08:00 to 16:00 hours** please call: **01482 608741**. For any further **information.** |  | **For all High Risk Patients**, from **Monday to Friday out of our****office hours** and over the **Weekend**, please contact the **Specialist****Nurse Stroke Coordinator on 01482 875 875 bleep 312**. |