Date: _ _ / _ _ / _ _ _ _
Time: _ _ : _ _ h

Hull University Teaching Hospitals NHS Trust

Department of Stroke Medicine

T.I.A. Clinic

NEURO-VASCULAR ASSESSMENT

e-REFERRAL FORM

Dr Rayessa Rayessa
Dr Ahmed Abdul-Hamid
Dr Irshad Ali

Dr Adnan Fazal
Dr Dimitri Marantos
Dr Akin Williams

Patient ID:
Surname:
Name:
Date of birth:
Address:
Telephone nº:

Patient Label

☐ General Practitioner
☐ Consultant
Name: _ _ _ _ _ _ _ _ _
Designation: _ _ _ _ _ _ _ _ _
Referred by: _ _ _ _ _ _ _ _ _ _ _
Ward / Department:
Practice / Address:
_ _
_ _
GP code nº: _ _ _ _ _ _ _ _ _
Tel. nº: _ _ _ _ _ _ _ _ _ _

PLEASE, TAKE A MOMENT TO COMPLETE THIS FORM

This referral must be authorised by the doctor responsible for this patient
The information requested is essential to us and the patient may have to be re-referred if this form is inadequately completed

YOUR HELP IS MOST APPRECIATED - THANK YOU

Suspected TIA

CLINICAL PRESENTATION *(please tick as appropriate)*

DATE OF SYMPTOM ONSET: _ _ / _ _ / _ _ _ _

VISUAL DISTURBANCE

RIGHT ☐   ☐ AMAUROSIS FUGAX ☐   ☐ LEFT
☐ HOMONYMOUS HEMIANOPIA ☐

SPEECH DISTURBANCE

☐ DYSARTHRIA
☐ DYSPHASIA ☐ EXPRESSIVE
☐ RECEPTIVE

FACIAL SYMPTOMS

RIGHT ☐   ☐ WEAKNESS ☐   ☐ LEFT
☐ NUMBNESS ☐
☐ PINS AND NEEDLES ☐

UPPER LIMB SYMPTOMS

RIGHT ☐   ☐ WEAKNESS ☐   ☐ LEFT
☐ NUMBNESS ☐
☐ PINS AND NEEDLES ☐
☐ INCOORDINATION ☐

LOWER LIMB SYMPTOMS

RIGHT ☐   ☐ WEAKNESS ☐   ☐ LEFT
☐ NUMBNESS ☐
☐ PINS AND NEEDLES ☐
☐ INCOORDINATION ☐

OTHER SYMPTOMS

☐ DIZZINESS
☐ DIPLOPIA

HIGH RISK PATIENTS

☐ ANTICOAGULATION
☐ ATRIAL FIBRILLATION OR ATRIAL FLUTTER
☐ RECURRENCE OF SYMPTOMS: Nº

BRIEF DESCRIPTION OF PRESENTING COMPLAINT:

Please, note that the following clinical features, when occurring alone, are unlikely to be a TIA symptom: Generalised weakness, confusion, amnesia, behavioural disturbance, seizure, headache, light-headedness, fainting, blurred vision, scintillating scotoma, isolated diplopia, tinnitus, dysphagia.

If a TIA is Suspected

- **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**
- **Please, advise patient not to drive for 4 weeks if single event or 3 months after the last event if recurrent symptoms**

For All High Risk Patients

- **From Monday to Friday out of our office hours (08:00 to 16:00 hours)**
- **Over the Weekend**

Please contact the Stroke Team Responder on 01482 875 875 bleep 312