Brightshores Health System

STROKE PREVENTION CLINIC REFERRAL FORM

Owen Sound 519-376 -2121 Ext 2922

Date of Event: _____ **Duration of Symptoms:** _____ **(min/hrs)**

Signs/Symptoms eg. Unilateral weakness, numbness, speech disturbances vertigo, vision changes

Side

R ☐ L ☐

_____

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Patient Legal Name ☐ F ☐ M

Address: _____

City: _____ Postal Code: _____

Phone #: _____

Alt. Phone #: _____

D.O.B: _____ /_____ /_____ (YYYY/MM/DD)

Health Card #: _____

Version Code: _____ Exp.: _____

Medication(s) (include dose & frequency):

Antiplatelets initiated/changed ☐Yes ☐No

Anticoagulation initiated/changed ☐Yes ☐No

_____

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Risk Factors: (Select all that apply)

☐ Atherosclerosis	☐ Family Hx Stroke	☐ Obesity(BMI>25)
☐ Atrial Fibrillation	☐ Hyperlipidemia	☐ Previous stroke/ TIA
☐ Depression	☐ Hypertension	☐ Sleep apnea
☐ Diabetes	☐ Ischemic heart disease	☐ Tobacco use

Investigation(s)to be scheduled (All applicable requisitions are linked)

☐ CTA (Head, Arch to Vertex) ☐ Yes ☐ No

☐ eGFR 30 or less - Page High Priority CT Radiologist

☐ CT Minus Head

☐ Carotid Doppler

☐ Echocardiogram ☐ Yes ☐ No

☐ Electrocardiogram ☐ Yes ☐ No

☐ Holter ☐ 7 day ☐ 14 day ☐ No

Laboratory Investigations (Please ensure requisition is completed)

☐ Na	☐ K	☐ Cl	☐ HDL	☐ eGFR
☐ CBC	☐ ALT/AST	☐ aPTT	☐ INR	☐ LDL
☐ Cr	☐ Hgb A1C	☐ Random BS	☐ Lipid profile	

Office Use Only

Notes: _____

_____

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Triage Level: _____

_____

Billing #: _____ Date: _____

Signature of Authorized Provider : _____

Print Provider Name: _____

Phone #: _____ Fax: _____

FAX COMPLETED FORM TO BRIGHTSHORES SPC:

519-378-1443

SPC will complete electro diagnostic testing once seen in clinic

INCLUDE SUPPORTING DOCUMENTATION

M-230 Revised Sept 2024

Brightshores Health System | HDH Hanover & District Hospital | South Bruce Grey Health Centre | Ontario | Stroke Network Southwestern Ontario

* P H Y 0 0 2 *

HOSPITAL ID: _____

Ontario Health West

OUTPATIENT CT REQUISITION FORM

Brightshores Health System **Fax: 1-855-702-1968**

PATIENT INFORMATION

SURNAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	PROVINCE	POSTAL CODE

MOBILE PHONE #	ALTERNATE PHONE #	EMAIL

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text Yes, e-mail

SEX ASSIGNED AT BIRTH	GENDER IDENTITY	DOB (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)
☐ Female ☐ Male	☐ Female ☐ Male ☐ Other			

HEALTH CARD NUMBER (HN)	VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)

☐ INTERPRETER REQUIRED Preferred language	ACCESSIBILITY CONCERNS OR REQUIREMENTS

ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME	CONTACT PHONE #

EXAM INFORMATION AND HISTORY

TEST/REGION(S) TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)

- ☐ **Head**
  - ☐ Brain
  - ☐ Sinuses
  - ☐ Facial Bones
  - ☐ Temporal Bones
  - ☐ Orbits
  - ☐ Circle of Willis
- ☐ **Neck**
  - ☐ Routine
  - ☐ Carotids
- ☐ **Spine**
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
  - ☐ Sacral/Coccyx
- ☐ **Thorax**
  - ☐ Routine
  - ☐ High-resolution
  - ☐ Pulmonary Embolism
- ☐ **Thorax/Abdomen /Pelvis**
- ☐ **Abdomen/Pelvis**
  - ☐ Routine
  - ☐ Renal Colic
  - ☐ Urography
  - ☐ Enterography
- ☐ **Musculoskeletal** (please Indicate)

☐ **OTHER EXAM TYPE** (please indicate)

REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

☐ **TIMED FOLLOW UP** **DATE REQUESTED** (YYYY/MM/DD)

CT availability is limited; requested dates will be accommodated where possible.

SCREENING & PRECAUTIONS

RENAL ASSESSMENT

☐ No known kidney issues

☐ Yes, patient has impaired renal function or a history of renal transplant

If yes, check all that apply: ☐ Has diabetes ☐ On dialysis

Please provide the most recent eGFR results (within the past 3–6 months)

eGFR RESULT (ml/min/1.73^2) **DATE COLLECTED** (YYYY/MM/DD)

- ☐ Known hypersensitivity to contrast agents
- ☐ Currently pregnant
- ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable
- ☐ Requires general anesthesia
  Rationale

For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.

REFERRING PROVIDER

PROVIDER NAME	BILLING #	PROFESSIONAL ID

ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE #	FAX #	COPY TO

PROVIDER SIGNATURE	DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No	SPECIFIED DATE

CCO ☐ Cancer ☐ No	PROTOCOL	RADIOLOGIST