

STROKE PREVENTION CLINIC REFERRAL FORM

Owen Sound 519-376 -2121 Ext 2922

Date of Event:

Duration of Symptoms: _____ (min/hrs)



PATIENT INFORMATION				
SURNAME		FIRST NAME		MIDDLE INITIAL
ADDRESS			CITY	PROVINCE
MOBILE PHONE #		ALTERNATE PHONE #	EMAIL	
Patient consents to appointment information being disclosed to them via text or e-mail <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, e-mail				
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		DOB (YYYY/MM/DD)	HEIGHT (CM) <input type="checkbox"/> WEIGHT (KG)
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
HEALTH CARD NUMBER (HN)		VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)
<input type="checkbox"/> 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)			REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)	
<input type="checkbox"/> Head <input type="checkbox"/> Spine <input type="checkbox"/> Thorax/Abdomen /Pelvis <input type="checkbox"/> Brain <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Sinuses <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Facial Bones <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral/Coccyx <input type="checkbox"/> Temporal <input type="checkbox"/> Sacral/Coccyx <input type="checkbox"/> Routine Bones <input type="checkbox"/> Thorax <input type="checkbox"/> High-resolution <input type="checkbox"/> Orbita <input type="checkbox"/> Routine <input type="checkbox"/> Pulmonary <input type="checkbox"/> Circle of Willis <input type="checkbox"/> Embolism <input type="checkbox"/> Enterography <input type="checkbox"/> OTHER EXAM TYPE (please indicate)			<input type="checkbox"/> Neck <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Routine <input type="checkbox"/> Renal Colic <input type="checkbox"/> High-resolution <input type="checkbox"/> Urography <input type="checkbox"/> Pulmonary <input type="checkbox"/> Enterography <input type="checkbox"/> Musculoskeletal (please Indicate)	
			<input type="checkbox"/> TIMED FOLLOW UP <input type="checkbox"/> DATE REQUESTED (YYYY/MM/DD) <i>CT availability is limited; requested dates will be accommodated where possible.</i>	
SCREENING & PRECAUTIONS				
RENAL ASSESSMENT	<input type="checkbox"/> No known kidney issues <input type="checkbox"/> Yes, patient has impaired renal function or a history of renal transplant If yes, check all that apply: <input type="checkbox"/> Has diabetes <input type="checkbox"/> On dialysis			<input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale <i>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.</i>
REFERRING PROVIDER				
PROVIDER NAME			BILLING #	PROFESSIONAL ID
ADDRESS			CITY	PROVINCE
PHONE #		FAX #	COPY TO	
PROVIDER SIGNATURE				DATE

OFFICE USE ONLY

PRIORITY	<input type="checkbox"/> P1	<input type="checkbox"/> P2	<input type="checkbox"/> P3	<input type="checkbox"/> P4	TIMED	<input type="checkbox"/> Yes	<input type="checkbox"/> No	SPECIFIED DATE
CCO	<input type="checkbox"/> Cancer	<input type="checkbox"/> No	PROTOCOL					RADIOLOGIST