

# STROKE PREVENTION CLINIC REFERRAL FORM

**Owen Sound 519-376 -2121 Ext 2922**

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

[illegible]

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 <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, e-mail				
SEX ASSIGNED AT BIRTH	GENDER IDENTITY	DOB (YYYY/MM/DD)	HEIGHT (CM)	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**

<b>TEST/REGION(S) TO BE EXAMINED</b> (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)	<b>REASON FOR EXAM / CLINICAL HISTORY</b> (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<input type="checkbox"/> <b>Head</b> <input type="checkbox"/> Brain <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Circle of Willis <input type="checkbox"/> <b>Neck</b> <input type="checkbox"/> Routine <input type="checkbox"/> Carotids	<input type="checkbox"/> <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral/Coccyx <input type="checkbox"/> <b>Thorax</b> <input type="checkbox"/> Routine <input type="checkbox"/> High-resolution <input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> <b>Thorax/Abdomen /Pelvis</b> <input type="checkbox"/> <b>Abdomen/Pelvis</b> <input type="checkbox"/> Routine <input type="checkbox"/> Renal Colic <input type="checkbox"/> Urography <input type="checkbox"/> Enterography <input type="checkbox"/> <b>Musculoskeletal</b> (please Indicate)	<input type="checkbox"/> <b>TIMED FOLLOW UP</b> <b>DATE REQUESTED</b> (YYYY/MM/DD) <i>CT availability is limited; requested dates will be accommodated where possible.</i>
<input type="checkbox"/> <b>OTHER EXAM TYPE</b> (please indicate)	

**SCREENING & PRECAUTIONS**

<b>RENAL ASSESSMENT</b> <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 Please provide the most recent eGFR results (within the past 3-6 months) <b>eGFR RESULT</b> (ml/min/1.73 <sup>2</sup> ) <b>DATE COLLECTED</b> (YYYY/MM/DD)	<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>
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**REFERRING PROVIDER**

PROVIDER NAME		BILLING #	PROFESSIONAL ID
ADDRESS		CITY	PROVINCE POSTAL CODE
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