**Transient Ischaemic Attack (TIA) Referral Form**

**Patients who have had a ?TIA need to be seen within 24 hours of first contact (unless the episode is already more than 7 days ago) – please send the referral as soon as possible after your assessment to avoid any delays.**

**They are more likely to have had a TIA if they have the following symptoms:**

1. ***Unilateral Face, Arm or Leg weakness***
2. ***Speech disturbance***
3. ***Transient visual loss***

**If patients have other symptoms, please review whether other causes could explain.**

**If patient has *ongoing* symptoms/signs, please consider whether the patient should follow the *acute stroke pathway* and be admitted to the nearest Hyperacute Stroke Unit (HASU).**

**Patient’s in ED/A&E/AAU may not require an urgent CT scan if you are confident the patient has NO ongoing symptoms or signs, unless the patient is on anticoagulants (or you have other concerns about haemorrhage or other non-stroke conditions requiring a CT).**

**The Stroke Consultants can be contacted in hours via the number on the last page or via switchboard.**

**Please ensure patients are referred to the on call medical team if the TIA occurs on Friday evening, Saturday or Sunday, otherwise all ?TIA patients can be discharged to be seen in the TIA Clinic Monday - Friday. Patients can have an MRI and Carotid Doppler when seen there.**

**Out of hours, if you have queries there is an on call Stroke Registrar and Consultant who can be contacted at St George’s Hospital (Tel: 020 8672 1255).**

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| **REFERRAL INFORMATION** | |
| **Source of referral: GP  ED  REU  AAU  Paramedic  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Date and time of first symptoms:**  date:      / time:      (24h clock)  **Date and time of first contact with health care professional :**  date:      / time:      (24h clock)  **Referring clinician details:**  **Referrer contact phone number:** | |
| **PATIENT INFORMATION** | |
| **SURNAME:** | **FIRST NAME:** |
| Date of Birth: | NHS Number: |
| Mr  Miss  Mrs Ms Other: | Home Tel: |
| Gender : M  F | Mobile /Daytime Tel. |
| Address: | Carer’s/NOK Name: |
| Carer’s/NOK Telephone number: |
| Transport required : Y N Type: |
| Handed? Left  Right |
| Preferred Language:  Interpreter required Y N |
| **Previous confirmed TIA or Stroke Y  N  If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **CURRENT SYMPTOMS** | |
| **Face, arm or leg weakness**  **Speech disturbance**  **Visual disturbance Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Have the symptoms/signs FULLY resolved? Y  N  If NO, IS THIS A STROKE!?**  **Brief History:**  **Past Medical History:** | |

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| **Risk Factors:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Previous TIA /Stroke** |  | **Known Carotid disease** |  | **Hyperlipidaemia** |  | | **Diabetes** |  | **Peripheral Vascular disease** |  | **Atrial Fibrillation** |  | | **Hypertension** |  | **Ischaemic Heart Disease** |  | **Alcohol** |  | | **Smoking** |  | **Impaired LV function** |  | **Obesity** |  | |

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| **TREATMENT** |

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| **Patient currently on Aspirin Y  N**  **Patient currently on Clopidogrel Y  N**  **Patient on anticoagulant (Warfarin or DOAC)? Y specify which:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N**  **If yes, why?**  **If on Warfarin, most recent INR and date of test:** | |
| **Current Drug Therapy:** | **Current Drug Therapy:** |
| **Please start Aspirin 300mg if not already on it and provide enough supply for one week**.  (If Aspirin intolerant consider alternative anti-platelet e.g. Clopidogrel)  **Please inform the patient they *must not drive* until seen in TIA Clinic**  **Please also attach a copy of any *ECG* that has been done to avoid duplication, thank you.** | |

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| **CLINIC INFORMATION** |

**Patients will be contacted by telephone Monday-Friday after their referral is received**.

**Patients should be encouraged to phone the number below on the next working day if they have not heard from us.**

**Hours of Clinic:** every weekday afternoon from 1:30pm

**Location:** ***Acute Assessment Unit (AAU)*** – patient will need to report to ***Acute Emergency Care (AEC) Reception***, Kingston Surgical Centre and may need to spend up to 3 hours at the appointment being assessed and having investigations.

Map Location: H – Level 3.



Kingston Hospital

Galsworthy Road

Kingston Upon Thames

Surrey, KT2 7QB

**Telephone:** **020 8934 2321 (Elderly Care (which includes TIA/Stroke) is option 4)**