Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Rapid Access TIA / Stroke Prevention Clinic Referral Form

Referral Process and Next Steps

High Risk	**All High-Risk referrals must be phoned through to Stroke Team immediately with patient present.** After advice from stroke nurse fill out referral and email to: Tiastrokepreventionreferrals@nnuh.nhs.uk Mon - Fri, 08:30 – 17:00 Tel: 01603 647478 **OR** 01603 288173 Out of hours and weekends Tel: 01603 646588

Low Risk	**Email referral immediately to** Tiastrokepreventionreferrals@nnuh.nhs.uk (hospital will contact patient direct within 7 days to arrange appointment)

Next Steps

1. If symptoms have completely resolved: Give aspirin 300mg unless contraindicated or on an Anticoagulant until seen in clinic
2. Ask patient to bring their medication list with them to the appointment/clinic
3. Inform patient: They should not drive AND If they develop any further focal neurology call 999 immediately

If you are unsure, please call the Stroke team on 01603 288185 or 01603 646588 for advice

Patient Details	
First Name:	Last Name:
Date of Birth:	Gender:
NHS Number:	Hospital Number:
Address:	
Post Code:	Home Phone:
Mobile Number:	Other Contact:
Patient Consent:	
☐ In line with GDPR, please confirm that you have spoken to the patient, and or parent / carer, and they have consented to the referral and the sharing of their data with this service	

Accessible Information Standards		
Please specify below if the **patient** and or **parent** / **carer**, have additional needs related to:		
	Patient:	**Parent / Carer:**
Vision		
Hearing		
Speech		
Other communication difficulties		
The patient, and or parent / carer, requires an: ☐ Interpreter (*specify language)* ☐ Lip speaker ☐ BSL interpreter		

Referrer Details			
Referrer Name:			
Position:		Contact Number:	
Referred from:	☐ GP / ☐ A&E / ☐ Ophth / ☐ AMU / ☐ EEAST / ☐ Other		
GP Name (if not referrer):		Practice Name:	
Referrer's Email:			

Assessment			
Clinical Impression / Short History			
Date/time of onset of symptoms:		Date/time of first contact:	
Patient's Blood Pressure:			
Clinical Features:			
Duration:		Diabetes:	
Patient has known AF	☐ Yes / No ☐	Or currently in AF	☐ Yes / No ☐
Does your patient have any of these?	☐ More than 1 event in 7 days	☐ On Anticoagulants DOAC or NOAC (This is not Aspirin)	

The patient **must** have experienced sudden onset of at least one of the following symptoms:	**What happened?** Provide details:
☐ Dysphasia ☐ Amaurosis fugax ☐ Hemianopia ☐ Loss of power OR sensation OR both, in face OR arm OR leg. ☐ **MORE THAN ONE** of Dysarthria, Vertigo, Double Vision, Ataxia, Dysphagia	

NB: One or more of: Blackout, Light headedness, Faintness, Dizziness, Total Body weakness, Fatigue, Drop Attacks or Amnesia are NOT LIKELY to be TIA. Consider referral to general / syncope / falls clinic.

ABCD² Score (Essential)			Score
A	Age	Score 1 if over 60	
B	BP	Score 1 if systolic BP >140 or diastolic >90	
C	Clinical Features	Score 2 for unilateral weakness OR score 1 for speech disturbance without weakness (max score is 2)	
D	Duration	Score 1 for 10-59 minutes, score 2 for >60 minutes	
D	Diabetes	Score 1 if known Diabetes	
		Total Score	/ 7
Definition of Score:		**High - ABCD2 score of 4+, or on Anticoagulant, or more than 1 event in a week** **Low - ABCD2 score of 3 or less**	

Medical History (or attach separately) Eye clinic referrals: send copy of eye notes

Medication (or attach separately)

Have you told patient not to drive? ☐ **Yes / No** ☐