

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@nuh.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@nuh.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: <input type="checkbox"/> GP / <input type="checkbox"/> A&E / <input type="checkbox"/> Ophth / <input type="checkbox"/> AMU / <input type="checkbox"/> EEAST / <input type="checkbox"/> 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	<input type="checkbox"/> Yes / No <input type="checkbox"/>	Or currently in AF	<input type="checkbox"/> Yes / No <input type="checkbox"/>
Does your patient have any of these?	<input type="checkbox"/> More than 1 event in 7 days	<input type="checkbox"/> On Anticoagulants DOAC or NOAC (This is not Aspirin)	

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

ABCD ² 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

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Medication (or attach separately)

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Have you told patient not to drive? Yes / No