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| **Transient Ischaemic Attack (TIA) Clinic Referral Form - EXTERNAL** |

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| **Please ring 07887 293695** and speak with Stroke Consultant OR stroke coordinator to discuss your referral. In some cases, we may ask you to redirect the referral or ask to see the patient urgently.  **Patients who have had a TIA need to be seen within 24 hours of first contact** with a healthcare professional, UNLESS the episode is already more than 7 days ago.  Please send referral as soon as possible after your assessment to avoid any delays  For further support please see Stroke section on our Urgent Clinical Advice Directory: <https://www.fhft.nhs.uk/gps/gp-centre/urgent-advice/> | | |
| 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 |  | **Email this form to:** [fhft.fphtiareferral@nhs.net](mailto:fhft.fphtiareferral@nhs.net)  NOTE: faxed referrals are no longer accepted |

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| **Patient Details** | | | |
| Name and Address: |  | **NHS no.** |  |
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| Home Phone: |  | | |
| Work Phone: |  | | |
| Mobile No.: |  | | |
| DOB: |  | Sex |  |

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| **GP Name** | |
| Surgery address: |  |
|  |  |
| Tel. no.: |  |
| Email: |  |
| **Contact Name:** |  |

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| **Mandatory Information** | | | | |
| **Without this information your referral will be rejected** | | | | |
| **Symptom Onset** | | | | |
| **Date** |  | **Time** |  | am/pm |
| **First Assessment by GP:** | | | | |
| **Date** |  | **Time** |  | am/pm |

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| **Are Patient’s symptoms atypical? Please Select X** | |
|  | * Gradual onset or spread of symptoms |
|  | * Seizure or loss of consciousness |
|  | * Transient Amnesia |
|  | * Isolated Vertigo and no other Cranial nerve features |
| **If ‘Yes’ to any of these questions STOP. This is unlikely to be a TIA.** Consider alternatives referral route, e.g. refer to General Medicine, General Neurology Clinic | |

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| **TIA Symptoms Please Select (X)** where yes | |
|  | Face weakness |
|  | Arm weakness |
|  | Leg weakness |
|  | Speech disturbance |
|  | Visual disturbance |
|  | Have symptoms/signs FULLY resolved |

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| **History of TIA Event:** Include details of focal neurology. |
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| **Past Medical History:** |
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| **Medications:** |
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| **Vascular risk factors:** Please Select **X** where yes | |
|  | Hypertension |
|  | Atrial fibrillation |
|  | Diabetes |
|  | Smoking |
|  | Ischaemic heart disease |
|  | Previous stroke |

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| **Patient Advice Please Select X as completed/advised** | |
|  | Advise Patient not to drive until seen at clinic |
|  | Aspirin 300mg stat and continue od until seen in clinic  (if NOT taking an or antiplatelet agent or anticoagulant) |
|  | Clopidogrel 300mg stat and 75mg od until seen in clinic  (if aspirin intolerant) |
|  | Any witness should accompany the patient to clinic |
|  | Patient should attend Frimley Park ED in the event of further symptoms |
|  | **Notify FPH TIA clinic of any patient mobility needs** |

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| **Accessible Information Needs (AIS):** |  |

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