 

**TIA Referral Form**

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| Name: | Referrer’s details |
| Date of Birth: | A&E: GP: Others: |
| Gender: | Position: |
| NHS Number: | Name: |
| Address: | Email id: |
| Contact Number: | Referral date and Time: |

**Detailed description of event** (if incomplete the referral will be rejected)

**It is unlikely to be TIA if:**

* **Seizure/ Loss of consciousness**
* **Isolated Amnesia**
* **Positive visual symptoms (eg: Flashing lights, etc)**

**Action Checklist for referrers**

**Time and Date of Symptoms onset: Onset**: Sudden / Gradual

**Duration of symptoms:**

**Episode Description:**

**Risk Factors** (Tick as appropriate): HTN/Diabetes Mellitus /Peripheral Artery Disease/Ischaemic Heart Disease /Atrial Fibrillation /Previous Stroke/TIA/ Active smoker

**Antiplatelets or Anticoagulation?**

Please give details if yes

**BP:**

* A TIA is a sudden onset focal neurological deficit lasting

<24 hours (average 10 minutes)

* If symptoms still present, treat as stroke and call 999
* If symptoms resolved, complete this proforma and email to buc-tr.tiareferralwycombe.nhs.net
* Give aspirin 300 mg daily until further review in TIA clinic.
* Advise the patient the DVLA mandates, no driving until medically cleared.
* All patients from ophthalmology should have an ESR sent from SMH

**For patients referred from Wexham Park Hospital, please *DO NOT refer concomitantly on EPIC***

**Does your patient have a: (please tick)**

* Pacemaker
* Eye Foreign Body
* Cochlear Implant
* Previous Brain surgery (Aneurysm clip etc)
* Pregnancy (this is a caution for MRI) These may be contraindications to MRI