WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE · NO EXCEPTIONS!

URGENT TIA CLINIC
REFERRAL FORM
FAX TO (519) 255-2285

(Please send all relevant diagnostic/lab results)

The referring physician MUST personally speak with the neurologist on call to discuss the eligibility of the patient.

Patient Name:_______________________ Phone Number:(___)_______________________

DOB:_______________________m/d/yy Health Card #:_______________________

Event Date:_______________________ Time:_____________

SIGNS / SYMPTOMS	SIDE (RIGHT/LEFT)
F-ace (Droop)	
A-rms (Weak)	
S-peech Difficulty	
T-ime (Length)	
Transient Painless Blindness	

ADDITIONAL COMMENTS (Please specify presenting symptom if not listed above):

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MEDS STARTED:

_____ASA 81mg po OD _____Loading dose of 160mg _____None

_____Clopidogrel 75mg po OD _____Loading dose 300mg

Comments: ____

____
NAME OF REFERRING PHYSICIAN

____
NEUROLOGIST CONTACTED

____
SIGNATURE

____
DATE

Has the patient consented to being contacted by telephone: ☐ Yes ☐ No

Has the patient consented to having a message left at the number provided: ☐ Yes ☐ No