STROKE PREVENTION CLINIC

Referral form

Tel# 416-242-1000- ext. 23400 Fax: 416-242-1094 1235 Wilson Ave., Toronto. ON M3M 0B2
4th Floor Medical Clinics

Date of Referral (dd/mm/yyyy): ________________

Patient Information (Please print clearly)

Last Name	First Name:	Male ☐ Female ☐ Other ☐
Date of Birth:	Health Card Number:	Version Code:
Home Address: City:	Province:	Postal Code:
Home Phone :	Cell Phone:	Work Phone:
Alternate Contact:	Relationship to Patient:	Phone Number:

Clinical Information (Check all that apply):

Reason for Referral:

Date of Onset of Symptoms (dd/mm/yyyy): ____

☐ **Unilateral Body Weakness** ☐ **Facial Droop**

☐ **Speech/ Language disturbance** ☐ **Other (Specify)**

Past Medical History:

☐ **Hypertension** ☐ **Diabetes** ☐ **A-FIB**

☐ **Dyslipidemia** ☐ **TIA/Stroke** ☐ **Other (Specify)**

Medications (please list):

Referring Care Provider Information

Referring provider name:	Billing Number:
Phone #:	Fax#:

Note: Please fax supporting documents (recent blood work, imaging results, consult notes, current medication list) with referral form to the clinic. Clinic will contact patient and referring provider with appointment details.