REFERRAL TO TIA SERVICES

Note: If symptoms of acute stroke are present dial 999

PATIENT DETAILS	**NHS No:**	
First name:	Surname:	
Title:	Male / Female	
DOB:	Contact number:	
Address:		
Interpreter required? (*if yes, state language required)*		
Date & Time of presentation to referring service:	Date:	Time:

Name of GP:	Name of GP Surgery:
GP Tel no:	

Referrer details (if not GP)

Name:	Organisation:
Tel no:	

CLINICAL DETAILS		Date & Time of onset:	Date:	Time:
Visual deficit:	Right / Left	Sudden in onset?	Yes / No	
Facial weakness:	Right / Left	Dysphasia/Dysarthria:	Yes / No	
Arm weakness:	Right / Left			
Leg weakness:	Right / Left			
Other Symptoms, please specify:				
HAS THE PATIENT BEEN GIVEN ASPIRIN 300mg? Yes / No *If contraindicated give Clopidogrel 300mg stat + 75mg/day*		If not, reason why:		

Risk Factors Present:			
History of Hypertension:	Yes / No	Known Hyperlipidaemia:	Yes / No
Diabetes Mellitus:	Yes / No	Ischaemic Heart Disease:	Yes / No
Atrial Fibrillation:	Yes / No	History of Stroke/TIA:	Yes / No
On Warfarin:	Yes / No	Smoker:	Current / Previous / Never
Alcohol (units/week):			
BP:		Pulse – rate and rhythm (regular or irregular):	

Has patient been informed that they should not drive for four weeks? **DVLA states automatic driving ban for 4 weeks.**	Yes / No

ABCD2 RISK SCORE – Please complete to ensure patient is prioritised appropriately by TIA service

	Risk Factor	**Category**	**Scoring System**	**Patient Score**
A	Age	≥ 60 years <60 years	1 0	
B	Blood pressure	>140mmHg systolic or >90 mmHg diastolic <140 mmHg systolic and < 90 mmHg diastolic	1 0	
C	Clinical Features	Unilateral weakness Speech impairment without weakness Other symptoms	2 1 0	
D	Duration of symptoms	≥ 60 minutes 10-59 minutes <10 minutes	2 1 0	
D	Diabetes	Yes	1	
		SCORE		

VERY IMPORTANT: This referral must be sent immediately

Past Medical History:
Current Medication:
Drug Allergies:
PLEASE TELL THE PATIENT AND/OR THEIR RELATIVE OR CARER THAT IF SYMPTOMS RECUR OR ANY NEW SYMPTOMS SUGGESTIVE OF STROKE DEVELOP THEY MUST CALL 999 IMMEDIATELY. **PLEASE HAND THE ACCOMPANYING INFORMATION LEAFLET BELOW TO THE PATIENT**

Name of Referrer:	Referrer Signature:

TIA Service to complete:

Date and time referral received:	Date:
Date and time of appointment:	Date:
Appointment time confirmed with patient:	Tick to confirm: ☐