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| **STEPPING HILL HOSPITAL TIA REFERRAL PROFORMA** newlogo-big | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient**  **Details** | | Forename: | | |  | | | | | | | | | | Surname: | | | | | | |  | | | | | | | NHS No | | |  | | | | |
|  | |  | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |  | | |  | | | | |
|  | | DoB: | | |  | | | | | | | | | | Male | | | | | | | Female | | |  | Contact Telephone | | | |  | | | | | | |
|  | |  | | |  | | | | | | | | | |  | | | | | | |  | |  | | |  | | | | | | |  | | |
|  | | Address: | | |  | | | | | | | | | |  | | | | | | |  | |  | | |  | | | | | | |  | | |
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| **Referrer Details** | | Referrer  Name : | | |  | | | | | | | | | |  | | | | | | | Department | | | | ED / AMU /GPAU /Eye clinic / Others | | | | | | | | | | |
|  | |  | | |  | | | | | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | |
|  | | Consultant | | |  | | | | | | | | | |  | | | | | | | Date /Time of Referral | | | | | |  | | | | | | | | |
|  | | |  | | | | |  | | | | | | |  | | | | | | |  | | | | | |  | | | | | | | | |
| Date/Time Symptom Onset: | | | | | |  | | | | | | |  | | | Was the event sudden in onset? | | | | | | | | | | | | Yes | | | No | | | | | |
|  | | | | | |  | | | | | | |  | | |  | | | | | | | | | | | |  | | |  | | | | | |
| Altered sensation in: | | | | | | Face | | | | | | | Yes | | | | No | | | |  | | Right side | | | | | Left side | | |  | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | |  | |  | | | | |  | | |  | | | | | |
|  | | | | | | Limbs | | | | | | | Yes | | | | No | | | |  | | Right side | | | | | Left side | | |  | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | |  | |  | | | | |  | | |  | | | | | |
| Loss of vision in one eye? | | | | | |  | | | | | | | Yes | | | | No | | | |  | | Right eye | | | | | Left eye | | |  | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | |  | |  | | | | |  | | |  | | | | | |
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| **Risk Factors (tick if yes)** | | | | | | |  | | |  | |  | | | | | |  |  | Reason for Referral: | | | | | | | | | | | | | | | |  | | |
| Hypertension | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| IHD | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Previous stroke/TIA | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Atrial Fibrillation | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Alcohol excess | | | | | | | | |  |  | |  | | | | | |  |  | Current Medication: | | | | | | | | | | | | | | | |  | | |
| Hyperlipidaemia | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Current smoker | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| On Anticoagulation | | | | | | | | |  |  | |  | | | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
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| BP: | / | | | | | | | | |  | | | |  | | | |  |  | Allergies: | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | |  | | | |  | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Pulse: | / minute | | | | | | | | |  | | | |  | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | |  | | | |  | | | |  |  |  | | | | | | | | | | | | | | | |  | | |
| Pulse: | Regular | | |  | | | Irregular | | | |  | | |  | | | |  | |  | | | | | | | | | | | | | | | |  | | |
|  |  | | |  | | |  | | | |  | | |  | | | |  | |  | | |
| Mon – Sun 7am -11 pm – If Crescendo TIA (i.e. the patient has had 2 or more episodes of TIA in a week ) then admit to HASU  Sat - Sun 11pm – 7 am – If crescendo TIA then discuss with the Stroke team at Salford Royal Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Give patient **Aspirin 300 mg** stat and for 14 days (if intolerant to Aspirin **give Clopidogrel 300mg** stat followed by 75 mg daily for 14 days) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | NO | |
| * Advise the patient that they **must not drive for 1 month** in line with DVLA regulations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Advice the patient to **ring 999 if they develop recurrence** of neurological symptoms | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * **Email this referral** to Appointments [snt-tr.StockportTIA@nhs.net](mailto:snt-tr.StockportTIA@nhs.net) Marjory Warren unit, Stepping Hill Hospital Tel No: 0161 419 5299 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REFERRAL FORMS WITH INADEQUATE INFORMATION WILL BE RETURNED TO THE REFERRER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |