

**TIA Referral Form**

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| **Patient’s Details:** | Referring Doctor’s Name: |
| Name: | Email: |
| Date of Birth: dd/mm/yyyy | Contact number: |
| Gender: F / M | GP Surgery Name: |
| NHS Number: | GP Name: |
| Address: | Practice Address: |
| Postcode: | Postcode: |
| Contact number (MUST be verified): | Practice Telephone Number: |

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| **Clinical Details:** |

**Symptom Onset Date & Time: dd/mm/yyyy \_:\_**

**First Assessment by Clinician Date & Time: dd/mm/yyyy**

**Please provide accurate clinical information and indicate the following (tick one) to help triage:**

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| ** Strong clinical suspicion that this patient has had a TIA and has a high risk of a stroke** |
| ** I would like second opinion about whether this patient has had a TIA** |

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| **Please provide a detailed event history:** |

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| **ABCD2 Score** | | |
| Age | >60 years | 1 |
| Blood pressure | Systolic >140  Diastolic >90 | 1 |
| Clinical | Other, no weakness  Speech disturbance only  Unilateral weakness | 0  1  2 |
| Duration | <10 minutes  10-59 minutes  >60 minutes | 0  1  2 |
| Diabetes | Yes | 1 |
| ABCD2 Score: | | |

**Are those symptoms still on-going?**

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| ** No** |
| ** Yes (it is not TIA, please refer patient to Emergency Department regarding assessment for a possible Stroke)** |

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| **The following factors will increase the urgency of an appointment at TIA Clinic:** |

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| **Patient with crescendo TIA (two or more TIAs in a week) within the last two weeks** |
| ** Patient in atrial fibrillation** |
| ** Patient already on anticoagulation** |
| ** Patient with known carotid stenosis (>50%)** |



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| **Past medical history:** |  | **Current medications:** |
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| **Atypical features:** |

**1. Loss of consciousness/Seizure/Unresponsive:**

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| **No** |
| **Yes (less likely TIA. Suspect Syncope, Vaso-vagal attack, Seizure/Epilepsy)** |

**2. Transient Global Amnesia:**

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| ** No** |
| **Yes (it’s not a sign of TIA)** |

**3. Isolated confusion:**

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| ** No** |
| **Yes (it’s not a sign of TIA)** |

**4. Gradual onset or progression of symptoms:**

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| ** No** |
| **Yes (less likely TIA. Consider migraine if patient had headache and/or photophobia and/or phonophobia and/or nausea and/or visual disturbance (‘flashing lights’, ‘zig-zags’, blurred vision) and/or felt ‘distant or disoriented’ )** |

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| **NOTE:**   1. **Prescribe Aspirin 300mg od (or Clopidogrel 300mg stat then 75mg od, if Aspirin allergic).** 2. **Do not alter medication if patient is already on Antiplatelet or Anticoagulant** 3. **Advise all patients not to drive until they have been seen by specialist (when definite guidance will be given)** |

**Please send a filled up TIA Referral Form by email** – [GWH.tiareferrals@nhs.net](mailto:GWH.tiareferrals@nhs.net)

**Contact number: 01793607353, Monday – Sunday, 8am – 6pm.**