***NOTE: Incomplete and / or unsigned requisitions will be returned***

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

# STROKE PREVENTION CLINIC REFERRAL FORM

Dr. David H. Kim, Stroke Neurologist
Linda Johnson, Stroke Nurse Practitioner

Markham Site Booking Line: (905) 472-7601
Fax: (905) 472-7621

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: _____

Patient Name (Last, First): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

| Date: | Referring MD | Signature | MD Phone# |
|---|---|---|---|
| | | | |

Additional Reports to:

Translator contact information for scheduling & accompaniment (name & number):

**Reason for Referral:**

_____

_____

_____

_____

_____

_____

**Send patient to the nearest hospital IF:**

**TIA or stroke symptoms occurred within 48 hours.**

**OR**

**transient, fluctuating or persistent unilateral weakness (face, arm and/or leg), or speech disturbance have occured within the past 2 weeks**

(reference: Canadian Stroke Best Practice Guidelines 2015)

**Please include with this referral form:**

- ☐ recent medical history
- ☐ recent bloodwork
- ☐ other pertinent test results

**Patient must bring to the appointment:**

- ☐ CD copy of any neuroimaging (CT or MRI) studies done outside of Markham Stouffville Hospital
- ☐ all medications
- ☐ a translator if patient does not speak English

**PATIENT SHOULD ARRIVE 15 MINUTES BEFORE THE SCHEDULED APPOINTMENT TO REGISTER AND TRAVEL TO THE CLINIC WAITING ROOM.**

**MSH staff will contact your patient directly to schedule an appointment time.**