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: ____

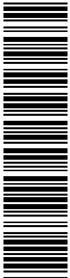
Date:	Referring MD	Signature	MD Phone#

Additional Reports to:

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

Reason for Referral:

- ☐ Remote history of stroke or TIA and needs an improved stroke or TIA prevention strategy
- ☐ Imaging evidence of stroke and needs a stroke prevention strategy
- ☐ Imaging evidence of carotid, vertebral, basilar, and/or intracranial vessel disease and needs a stroke prevention strategy
- ☐ For consideration of enrollment into the Lifestyle Education and Exercise program (LEEP) for secondary prevention of stroke or TIA
- ☐ Other: ____



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.