**TIA Referral Form**

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| **REFERRER DETAILS** | | Referred from: GP ED OOH ACU Eye clinic other (Please circle) | | |
| Referrer Name: | | | Practice / Ward / department: | |
| GP Name and address: | | | | |
| Referrer Telephone No: | | | Today’s date: **DD / MM / YYYY** | |
| **PATIENT DETAILS** | | | | |
| Forename: | | | Surname: | |
| Date of birth: | | | Gender: | |
| Hospital Number: | | | NHS Number: | |
| Address: | | | | |
| **IMPORTANT - Contact phone number(s) for patient in next 72 hours (verified):** | | | | |
| **CLINICAL FEATURES** | | date and time of symptom onset: **DD / MM / YYYY** at : hours | | |
| date and time of first clinical contact: **DD / MM / YYYY** at : hours | | |
| The patient must have experienced at least one of the following symptoms:   * Speech disturbance (dysphasia / dysarthria) * Amaurosis fugax or Hemianopia * Loss of power or sensation or both, in face / arm/ leg. * **MORE THAN ONE** of dysarthria, Vertigo, double Vision, ataxia or dysphagia | | | **What happened? Please give details:** | |
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| **Further information, relevant PMH and risk factors:** | | | | |
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| **NB:** one or more if: Loss of consciousness, Light headedness/Faintness/dizziness, Total body weakness or Fatigue, drop attacks or amnesia are NOT LIKELY to be TIA. Consider referral to General clinic, Falls, Neurologist | | | | |
| **TIA ABCD2 Score** | | | | **Score** |
| **A** | age | Score 1 if over 60 | |  |
| **B** | bp | Score 1 if systolic bp more than 140 and/or diastolic more than 90 at presentation | |  |
| **C** | Clinical Features | Score 2 for unilateral weakness, score 1 for speech disturbance without weakness | |  |
| **D** | duration | Score 1 for 10-59 minutes, score 2 for more than 60 minutes | |  |
| **D2** | diabetes | Score 1 if know diabetes | |  |
| **Total Score** | | | |  |
| **HIGH RISK: ABCD2 Score 4 or more, OR more than 1 TIA in 7 days OR TIA and on Warfarin** | | | **LOW RISK: ABCD2 Score less than 4,**  **OR event more than 7 days ago** | |
| Target: High risk to be seen in Tia clinic within 24 hours of first clinical contact, all others within 7 days  Consider admission to GrH of High risk patients if cannot be seen in time, or clinical need for emergency assessment  **09:30–15:30 Monday-Friday:** While with patient, phone Tia clinic booking line for appointment details via **Single Point of Clinical Access (SPCA) 08454 220 300 and then fax this form to 08454 226326**  **Outside these hours:** Fax this form to 08454 226326 and warn the patient to expect a call with an appointment | | | | |
| **All patients: Give aspirin 300mg unless contraindicated or on Warfarin** | | | | |
| **All patients: Tell patient not to drive** | | | | |
| **Current Medication List:** | | | | |
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To be Filed iN THe CorreSpoNdeNCe SeCTioN oF THe HealTH reCord.



GHNHSFT/ **Y0491**/06\_12