University Hospitals of Leicester NHS
NHS Trust

DAILY TIA CLINIC REFERRAL FORM
Department of Stroke Medicine, Leicester Royal Infirmary

Please fax to 0116 258 (6730)	**Clinic clerk will contact patient directly**

Patient Name	GP Name
Address	Address
Postcode	
DOB	
Hospital / NHS No	Postcode
Preferred Contact No (Mobile preferably)	Contact No
	Fax No

1. This form is reviewed and updated regularly on the UHL website and DONUT, please use directly.
2. ADMIT IF
   a. on anticoagulants & symptoms within 7 days, for urgent neuroimaging even if resolved.
   b. residual signs / symptoms imply Stroke **(possible thrombolysis, discuss if suitable for urgent transfer)**
3. **Crescendo TIAs** (i.e. > 1 in last week) **– if clinical concerns, admit or discuss with stroke consultant on call.**
4. Associated loss of consciousness makes TIA very unlikely. Please consider "UHL Syncope Pathway"
5. **TELL PATIENT that they "must not drive"** until seen in clinic.
6. Administer **Aspirin 300mg STAT** ☐ and prescribe TTO:Aspirin 300mg OD ☐ + Simvastatin 40mg OD ☐. *(in ED: prepacks stocked in minors 'medi365')*
7. Give FAST information, in case of recurrence of symptoms

CLINICAL FEATURES

Date and time of symptom onset: Exact onset: ___ / ___ / 20____ ____:____hrs OR On waking at ____:____hrs ☐	**Date and time** of first professional health contact: GP/ 999 / ED / Nurse / ECP / other _____**(pl.circle)** ___ / ___ / 20____ ____:____hrs

Brief description of symptoms (specify side)

Provisional Diagnosis TIA ☐ Stroke ☐ Other ☐ _____

Premorbid state Independent ☐ Daily help with personal care ☐
Can go up & down a flight of stairs ☐ Nursing Home ☐

Risk factors	**Current treatment**
ECG SR ☐ AF ☐ Other ☐	
BM	

(ABCD2 ≥4 or Crescendo TIA implies high risk of imminent stroke, and we will aim to see within 24 hrs)

ABCD2 Score

AGE:	≥ 60 yrs	**1** ☐
	< 60 yrs	**0** ☐
BP:	SBP≥140 or DBP≥90	**1** ☐
	SBP<140 & DBP<90	**0** ☐
CLINICAL FEATURES		
Unilateral Weakness +/- speech difficulty		**2** ☐
Left ☐ **Right** ☐		
Speech difficulty without weakness		**1** ☐
Other		0 ☐
DURATION OF CLINICAL FEATURES		
≥ 60 min		**2** ☐
10-59min		**1** ☐
<10mins		**0** ☐
DIABETES		
Yes		**1** ☐
No		**0** ☐

TOTAL ABCD2 Score =

Crescendo TIA Yes ☐ No ☐

Referrer Details

Name: …… **Signed:** ..... **Date:**..... **Contact No:**……

Source of referral: **[Ward __ LRI/LGH/GH/ED] [Practice GP/Oncall GP – surgery_____]**
(Please circle) **[Other _____]**

Patient or carer to call 0116 258 5431 if no appointment within 24 hours, ALL boxes must be filled in legibly

Refer to associated document: TIA - UHL guideline for initial management