

PETERBOROUGH REGIONAL HEALTH CENTRE

Stroke Prevention Clinic Referral

t: 705-743-2121 x. 8321 | f: 705-876-5172

Date of Referral (DD/MM/YYYY): _____

PATIENT LABEL

If symptoms occurred within the last 48 hours, the patient should be assessed immediately in the Emergency Department as per Canadian Stroke Best Practice Recommendations.

Client/Patient Information		
Last name:		First name:
How do you describe your gender: ☐ Woman ☐ Man ☐ Non-binary ☐ Two-Spirit ☐ Prefer to self-describe: _____ ☐ Prefer not to disclose		
DOB (DD/MM/YYYY):	Health card number:	Version code:
Address:		

Referring Physician Information	
Name (please print):	Billing number:
Family physician:	

Reason for Referral	
☐ TIA ☐ Ischemic Stroke ☐ Hemorrhagic Stroke Other: _____	

Description of Symptoms	
Date of Symptom Onset (DD/MM/YYYY):	Duration: ☐ Minutes ☐ Hours ☐ Days
Did all symptoms resolve? ☐ Yes ☐ No	

Motor: (R / L) ☐ Face ☐ Arm ☐ Leg	Speech: ☐ Dysarthria ☐ Aphasia
Sensory: (R / L) ☐ Face ☐ Arm ☐ Leg	Visual: ☐ Monocular ☐ Field Loss ☐ Diplopia
Other: _____	

Referral Criteria (please forward all results once complete)

1. Complete/Order all of the following investigations:
- a. CT and CTA of the head (arch to vertex) MUST BE ORDERED
 - i. Carotid dopplers will be accepted in place of CTA only if medically unable to complete CTA (e.g. allergy to contrast)
 - b. ECG (fax actual ECG)
 - c. Lipids, glucose, HbA1C
 - d. Basic bloodwork: CBC, electrolytes, creatinine
- *The tests above must be ordered as results are necessary for appropriate triage.**
2. If confirmed stroke on imaging then order echo and holter at time of referral, otherwise need for these tests can be assessed in clinic
3. Recent Blood pressure: _____
4. Please provide patient with the Patient Information Sheet . Incomplete referrals will be declined.

For all patients, please attach the relevant clinical notes, list of medications and investigations (bloodwork, cardiac testing and neuroimaging) to the referral. Referrals will be triaged and appointments booked based on the Ontario Triage Algorithm for Stroke Prevention Clinics and clinic availability.

Name: _____ Signature: _____ Date (DD/MM/YYYY): _____

Internal Use

Triaged to Dr. _____ Urgency: _____ Date (DD/MM/YYYY): _____

One team, here when you need us most.

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Form #XXXX, Revised September, 2026