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| **SALFORD ROYAL NHS FOUNDATION TRUST - REFERRAL TO TIA SERVICES**  **EMAIL to** [**Salford.TIA@nca.nhs.uk**](mailto:Salford.TIA@nca.nhs.uk)  ***Please note if more than one episode within two weeks contact stroke registrar on 0161 206 0070****.* | | |
| **PATIENT DETAILS** | **NHS No:** | |
| First Name: | Surname: | |
| Title: | Male / Female | |
| DOB: | Contact Number: | |
| Address: | | |
| Interpreter required? *(if yes, state language required)* | | |
| Date & Time of presentation to referring service: | Date: | Time: |

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| Name of GP: | Name of GP Surgery: |
| GP Tel No: |

**Referrer Details (if not GP)**

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| --- | --- |
| Name: | Organisation: |
| Tel No: |

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| **CLINICAL DETAILS** | | Date & Time of onset: | Date: | Time: |
| Visual deficit: | Right / Left | Sudden in onset? | Yes / No | |
| Facial weakness: | Right / Left | Dysphasia / Dysarthria: | Yes / No | |
| Arm Weakness: | Right / Left | Leg Weakness: | Right / Left | |
| Other symptoms, please specify: | | | | |
| HAS THE PATIENT BEEN GIVEN ASPIRIN 300mg?  Yes / No  *If contraindicated give Clopidogrel 300mg stat + 75mg/day* | | If no, reason why? | | |
| ***STOP* – Does your patient take anticoagulants? If so they require urgent CT brain imaging and should be discussed with stroke registrar please contact 0161 206 0070.** | | | | |
| **Has service user been informed that they are not to drive for four weeks / or until reviewed n TIA clinic?**  **This is a DVLA requirement. If you are unsure of guidelines please access them via:**  https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals | | | | Yes / No |

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| **RISK FACTORS PRESENT** | | | |
| History of hypertension: | Yes / No | Known hyperlipidaemia: | Yes / No |
| Diabetes mellitus: | Yes / No | Ischaemic heart disease: | Yes / No |
| Atrial fibrillation: | Yes / No | History of Stroke/TIA: | Yes / No |
| On warfarin: | Yes / No | Smoker: | Current / Previous / Never |
| Alcohol (units/week): |  | | |
| BP: | Pulse – rate and rhythm (regular or irregular: | | |

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| Past Medical History: |
| Current Medication: |
| Drug Allergies: |

**ABCD2 RISK SCORE –** Please complete to ensure patient is prioritised appropriately by TIA service

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|  | **Risk Factor** | **Category** | **Scoring System** | **Patient Score** |
| **A** | Age | ≥ 60 years  < 60 years | 1  0 |  |
| **B** | Blood Pressure | >140mmHg systolic or >90mmHg diastolic  <140mmHg systolic and <90mmHg diastolic | 1  0 |  |
| **C** | Clinical Features | Unilateral weakness  Speech impairment without weakness  Other symptoms | 2  1  0 |  |
| **D** | Duration of symptoms | ≥ 60 minutes  10 – 59 minutes  < 10 minutes | 2  1  0 |  |
| **D** | Diabetes | Yes | 1 |  |
|  |  | **SCORE** |  |  |

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| **PLEASE TELL THE PATIENT AND / OR RELATIVE OR CARER THAT IF SYMPTOMS RECUR OR ANY NEW SYMPTOMS SUGGESTIVE OF STROKE DEVELOP, THEY MUST CALL 999 IMMEDIATELY** |