Croydon TIA OPEN ACCESS REFERRAL FORM
FOR USE BY GENERAL PRACTITIONERS

Croydon University Hospital NHS Trust **TIA OPEN ACCESS CLINIC** **REFERRAL FORM** (and vital signs data capture form**)** ****FAX NUMBER: 020 8401 3620** (Please fax referral urgently) **GP STAMP(name and address)**	**Source of referral** (please ring): GP | A&E | MAU | Paramedic | Other ***Date and time of First Contact with GP*** Date__/__/__: time __:__ (24h clock) **Name of referrer and contact phone number:** **Date and time of referral:** Date__/__/__: time __:__ (24h clock)
Patient details **Name :** Sex : D.O.B. : **Address:** **Tel. No.:** Registered GP:	**Date and time of onset of symptom(s) and brief history** **Previous TIAs or Stroke? Yes / No** **If yes, when and how many?**

ABCD2 SCORE if presenting within 7 days	**POTENTIAL POINTS**	**POINTS**
Age >/=60	1	
< 60	0	
BP Systolic >140 or Diastolic ≥ 90	1	
Systolic <140 & Diastolic < 90	0	
Clinical features		
Unilateral weakness	2	
Speech disturbance	1	
Sensory Loss/ other symptoms	0	
Duration >/= 60 minutes	2	
10 – 59 minutes	1	
< 10 minutes	0	
Diabetes Present	1	
Absent	0	
TOTAL SCORE	-	

If score 4 or above, or more than 1 TIA in a week, or on anticoagulant follow high risk pathway

Current Drug Therapy:

Please start aspirin 300mg of immediately. If aspirin intolerant consider alternative anti-platelet

Please specify: -

- If on Aspirin at time of event and/or other anti-platelet drug(s)

If on Warfarin and why? Most recent INR with date (if known):

Please tick any known additional risk factors:

Previous TIA / CVA,	IHD	Known carotid disease	Atrial Fibrillation
Hypertension,	Diabetes,	Impaired LV function	
Hyper-lipidaemia,	Smoking,	Peripheral vascular disease	