

# URGENT TIA CLINIC FAST TRACK REFERRAL FORM

(Please use ICE electronic referrals whenever possible)

Royal United Hospital Bath



NHS Trust

**ALL PATIENTS: PLEASE TELL PATIENT NOT TO DRIVE**

Referred from (please tick):	GP <input type="checkbox"/>	ED <input type="checkbox"/>	OOH <input type="checkbox"/>	MAU <input type="checkbox"/>	Other <input type="checkbox"/> (Please State: _____)
<b>PATIENT DETAILS:</b>					
Forename:		Surname:			
Date of Birth:		Sex:			
Hospital Number:		NHS Number:			
Address:					
Post Code:					
Important – Contact phone number(s) for patient in the next 72 hours (verified) including mobile:					
<b>PRACTICE DETAILS:</b>					
GP Name:			Practice:		
Address:					
Telephone Number:			Today's Date:		
<ul style="list-style-type: none"> <li>Diagnosis of TIA: focal neurological symptoms which <u>completely resolve</u> within 24 hours. If history suggests migraine, consider referral to neurological services.</li> <li>Diagnosis of TIA unlikely if the following are present - confusion/isolated vertigo/loss of consciousness/light-headedness/faintness/dizziness/total body weakness or fatigue.</li> <li><b>If patient has persistent symptoms or signs when seen, is anticoagulated or has had more than 1 event in 24 hours, consider admission to ED.</b></li> </ul>					
<b>Clinical Features</b>	Yes	Right	Left	<b>Date &amp; Time of Event:</b>	
Hemiparesis/arm weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date:</b>	<b>Time: (24h Clock)</b>
Hemi-sensory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date &amp; Time of Referral:</b>	<b>Time: (24h Clock)</b>
Loss of vision one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Date:</b>	
Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Drugs:</b>	
Diplopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Incoordination/ataxia	<input type="checkbox"/>				
Dysphasia	<input type="checkbox"/>				
Dysarthria	<input type="checkbox"/>				
True Vertigo	<input type="checkbox"/>				
Further information/relevant PMH and risk factors:					
<b>TIA ABCD2 Score</b>					<b>Score:</b>
<b>A</b>	Age	Score 1 if over 60			
<b>B</b>	BP	Score 1 if systolic BP >140 or diastolic >90 at presentation			
<b>C</b>	Clinical Features	Score 2 for unilateral weakness, Score 1 for speech disturbance without weakness			
<b>D</b>	Duration	Score 1 for 10-59 minutes, Score 2 for >60 minutes			
<b>D2</b>	Diabetes	Score 1 if known Diabetes			
<b>High Risk Score = 4 or more Low Risk Score &lt;4</b>					<b>Total:</b>
<b>Referral Pathway for Suspected TIA:</b>					
1	Perform ABCD2 score as above				
2	Start Aspirin 300mg od (If intolerant Clopidogrel 300mg stat then 75mg od)				
3	Take bloods in primary care if possible including glucose and lipid levels				
4	Fax referral to Alison Jones, TIA Administrator on 01225 821287				

