PLEASE ENSURE ALL SECTIONS ARE FULLY COMPLETED

EAST & NORTH HERTFORDSHIRE NHS TRUST

TIA REFERRAL FORM

PATIENT DETAILS				
Title:	**Name:**	**DOB:**	**Age:**	**NHS No:**

CONTACT NUMBERS (please mark preferred contact number)		**ADDRESS**
☐ Home:	☐ Consent to leave voicemail message	
☐ Mobile:	☐ Consent to leave voicemail message	
☐ Work:	☐ Consent to leave voicemail message	
☐Other:	☐ Consent to leave voicemail message	
Patient Email: Click here to enter text.	☐ Consent to use email to contact patient	

NB Patient will be contacted by the hospital, and expected to attend their appointment within 24 hours of receipt of referral if symptoms were within the last 7 days or identified as high risk , or within 7 days if last episode more than a week ago

Interpreter required? If yes language: Click here to enter text.	Choose an item.
Hearing difficulties?	Choose an item.
Cognitive difficulties?	Choose an item.
Mental Capacity Assessment required?	Choose an item.
Learning Disability?	Choose an item.
Known safeguarding concerns?	Choose an item. If yes, provide details Click here to enter text.
Mobility requirements/ transport issues	Choose an item. If yes, provide details Click here to enter text.
Information Leaflet given Choose an item. **Patient aware they need to attend** Choose an item.	**Dates/Times when patient is definitely unavailable:** Click here to enter text.

GP DETAILS	
Referring GP Name: **Provide by pass Tel:** Click here to enter text. **Fax:** **Practice e-mail:**	**Practice Code:** **Practice Address:**

IF THE PATIENT STILL HAS SYMPTOMS/SIGNS, REFER AS AN EMERGENCY VIA THE SUSPECTED STROKE PATHWAY (BLUE LIGHT AMBULANCE TO NEAREST E.D. AT A HOSPITAL WITH HASU STATUS)

ATYPICAL FEATURES		
If 'yes' to any of these at onset, TIA is an unlikely diagnosis, so consider alternative referral route. An urgent neurology out-patient referral is generally required for these presentations. **If in doubt discuss with Stroke Consultant immediately: Contact details: 01438 314333 (switchboard number)**	**Gradual onset or spread of symptoms (hours to days)**	Choose an item.
	Seizure or loss of consciousness without a residual focal neurological deficit	Choose an item.
	Transient Amnesia unaccompanied by a focal neurological deficit	Choose an item.

Details of discussion with consultant (including their name) if TIA clinic referral advised after discussion:

Click here to enter text.

TIMINGS		
First onset of symptoms?	**Date:** Click here to enter a date.	**Time:** Click here to enter text.
If they have had more than one episode, when did they last notice their symptoms?	**Date:** Click here to enter a date.	**Time:** Click here to enter text.
When were they first seen by GP/Nurse re their suspected TIA	**Date:** Click here to enter a date.	**Time:** Click here to enter text.

ANTI-COAGULATION AND AF STATUS	
Is the patient is taking anticoagulant therapy? Choose an item.	(Delete any that don't apply) **Warfarin/Acenocoumarol/Phenindione** Date & result of latest INR Click here to enter text. **Heparin/low molecular weight heparin** **NOAC: Apixaban/Dabigatran/Rivoroxaban**
Previous AF **Details:**	Choose an item. Click here to enter text.
Suspected new AF **Details:**	Choose an item. Click here to enter text.

PRESENTING COMPLAINTS/PRESENTATION

RISK STRATIFICATION USING THE ABCD2 SCORE			Enter Value
Age 60 or over	Patient Age:	Yes = 1, No = 0	Click here to enter text.
BP 140 systolic and/or90 diastolic or over (initial reading)	Latest BP:	Yes = 1, No = 0	Click here to enter text.
Clinical features	Unilateral Weakness	= 2	Click here to enter text.
	Speech disturbance without weakness	= 1	Click here to enter text.
	Other symptoms	= 0	Click here to enter text.
Duration of symptoms	60 minutes or more	= 2	Click here to enter text.
	10-59 minutes	= 1	Click here to enter text.
	9 minutes or less	= 0	Click here to enter text.
History of diabetes		Yes = 1	Click here to enter text.
More than 1 episode within the last week		Yes = 4 No = 0	Click here to enter text.
Now add the score up. **Proceed with High risk TIA referral if score 4 or more** **Proceed with Low Risk TIA referral if score is 3 or less**			Click here to enter text.

ACTIONS

1) **Give aspirin 300mg unless there is a contraindication or the patient is already on anticoagulation (see clinical pathway (on ENHCCG website):** Primary Care Anti-platelet Therapy in Suspected TIA - http://www.enhertsccg.nhs.uk/pathways?field_pathway_keywords_tid=Anti-platelet+&field_specialty_tid=All&field_pathway_or_referral_tid=1368&=Apply

2) **Give patient leaflet**

3) **Emphasise:**

- **a.** **Must call 999 immediately if symptoms recur, and state "suspected stroke"**
- **b.** **The need to be available to attend TIA clinic within 24 hours if High Risk and 7 days if Low Risk**
- **c.** **The importance of prompt attendance to reduce the risk of stroke**
- **d.** **No driving until seen in TIA clinic (and for 1 month thereafter if TIA is confirmed)**

4)

- **a.** **Get ECG and give copy to patient to take to TIA clinic (as long as this does not delay the patient being referred to clinic)**
- **b.** **Provide the patient with previous relevant pathology results to take to appointment (or enter details in the space below)**

5) **Organise blood tests for assessment and secondary prevention. The patient could have the blood taken when they are at the hospital attending their TIA clinic appointment: HbA1c, lipids, LFTS, Creatinine and electrolytes, and ESR if the patient is young and/or giant cell or other arteritis is suspected. Please also request a clotting screen if the patient is in AF and not yet anti-coagulated**

RISK FACTORS	YES/NO	COMMENTS
Hypertension	Choose an item.	Last 5 BP readings:
Hyperlipidaemia	Choose an item.	Click here to enter text.
Previous Stroke or TIA	Choose an item.	Click here to enter text.
IHD	Choose an item.	Click here to enter text.
PVD	Choose an item.	Click here to enter text.
FH CVD	Choose an item.	Click here to enter text.
Smoker, If yes – date of last quit attempt	Choose an item.	Click here to enter text.

DECIDE ON REFERRAL ROUTE

SEND ALL TIA REFERRALS NOW TO ListerTIA.enh-tr@nhs.net

IF

1) Last episode was within the past 7 days

OR

2) Last episode was over 7 days ago but the patient has an ABCD2 score 4 or more

DO NOT DELAY THE REFERRAL TO GET ECG OR ORGANISE BLOOD TESTS.

SEND ALL TIA REFERRALs TODAY TO ListerTIA.enh-tr@nhs.net

IF

1) Last episode more than 7 days ago AND ACBD2 score 3 or less

PAST MEDICAL HISTORY

Click here to enter text.

ALLERGIES

Start date	Allergy or Sensitivity	Details	Allergy (no Read Code) or Sensitivity
Click here to enter a date.		Click here to enter text.	Click here to enter text.

LATEST BLOOD RESULTS

Please enter important relevant pathology results
Click here to enter text.

RADIOLOGY RESULTS (Last 5 years)

Click here to enter text.

MEDICATIONS