

**RAPID ACCESS STROKE PREVENTION  
TIA CLINIC REFERRAL PROFORMA – FAX REFERRAL ONLY**

Complete and **fax** to RASP clinic (021 4920355) for patients with

- Focal** neurological symptoms lasting < 24 hours who have made a **complete recovery**
- No residual neurological symptoms or signs**
- No red flags for immediate admission and ABCD2 score 0-4**

Date of symptoms: / / Date of referral: / / Referring Dr: Contact Number:

**PATIENT DETAILS**

Patient Name:  
Date of birth: Age:  
CUH MRN if known:  
Address:

**NB** Mobile Telephone:  
Mobile Next of kin:

**IMPORTANT!**

- Isolated dizziness, collapse “query cause” and blackouts are almost never due to TIA, and should be referred instead to ED/assessment**
- DO NOT SEND FORMS BY POST OR CUH INTERNAL MAIL – They will not be received or processed. All referrals must be faxed. Fax: 021 4920355. Enquiries to 021 4920350**

Reg flags for urgent same day admission?	Yes	No
Any residual neurological symptoms		
Any residual neurological signs		
Recurrent TIA (> 1 in last 4 weeks)		
Known ipsilateral severe carotid stenosis		
In Atrial fibrillation, not on warfarin/anticoagulant		

If **YES** to any of the above, refer directly to **AMAU 8am-6pm** or **ED 6pm to 8am**

Driving status documented: **Y / N** Advised to stop driving: **Y / N**

**DESCRIPTION OF SYMPTOMS (include nature of all focal symptoms, duration, recurrences):**

---



---

**TIA RECURRENCE RISK STRATIFICATION (ABCD2 SCORING)**

<b>Age</b>	≥ 60	1	<input type="text"/>	<b>TOTAL</b>
	< 60	0	<input type="text"/>	
<b>BP</b>	≥ 140 / ≥ 90	1	<input type="text"/>	
	< 140 / < 90	0	<input type="text"/>	
<b>Clinical symptoms/signs</b>	Hemiparesis	2	<input type="text"/>	
	Only Speech disturbance	1	<input type="text"/>	
	All others	0	<input type="text"/>	
<b>Duration</b>	> 60 mins	2	<input type="text"/>	
	10 – 59 mins	1	<input type="text"/>	
	< 10 mins	0	<input type="text"/>	
<b>Diabetes</b>	Yes	1	<input type="text"/>	
	No	0	<input type="text"/>	
				<input type="text"/>

**Medications (please fax list of medicines and past history)**

**ABCD2 score 0 to 4:** Fax this form to Rapid Access Stroke Prevention Clinic 021 492 0355  
**ABDC2 score 4+ or red flags:** Refer same day directly to ED or 9am-5pm AMAU  
**From 4pm Friday to 9am Monday follow same format, referring to ED high risk or ABCD2 >4 patients**

Triaged as suitable **Y N** Clinic date \_\_\_\_\_

Patient telephoned/to fast  GP informed if unsuitable

MRI CT