REFERRAL for TIA/Non-Disabling Stroke		Patie	Patient information		
Saskatchewan Acute Stroke Pathway					
** Highest risk TIA patients: contact ACAL / Bedline for urgent discussion with neurologist **		ie			
Stroke Prevention Clinics: Saskatoon (fax 306-655-6803) 07:30 to 16:00 closed weekends & holidays		Patie	Patient address:		
☐ Regina (fax 306-766-3959) 08:00 to 16:00 closed weekends & holidays		Alte	Alternate contact name:		
☐ Prince Albert (fax-763-2101) call for hours (306) 763-6464		Pho	Phone:		
☐ Yorkton (fax 306-786-0892) call for hours (306) 786-0890					
Referral Source: Emergency Department Physician Nurse Practitioner Inpatient ward					
Referring provider		Date	ate Time		
Date / time of symptom onset	Blood Pressure		Family Physician		
As of referral date when did symptom(s) begin? Within the past 48 hours Within 48 hours to 2 weeks Greater than 2 weeks ago Symptoms (check all that apply): unilateral motor weakness (face, arm and/or leg) speech disturbance hemibody sensory loss acute monocular vision loss, binocular diplopia or hemivisual loss ataxia other Note: isolated syncope or dizziness is rarely a TIA; consider referral to general neurology and/or cardiology			may apply. Please initiate investigations,		
Duration of symptoms: ☐ less than 10 minutes ☐ 10 to 59 minutes ☐ greater than 60 minutes					
Please provide a brief description of the event and/or a clinical note:					
				Therapy: Patient started on antiplatelet/ anticoagulant? ☐ YES ☐ NO Dosage & date started:	
Relevant health history (check all that apply): ☐ previous stroke or TIA ☐ hyperlipidemia ☐ diabetes ☐ hypertension atrial fibrillation ☐ coronary artery disease ☐ carotid disease ☐ other				on	
Investigations (Fax results with this referral): Ordered Co		Comple	eted		
CT Scan of head CT Angiogram Carotid Ultrasound				☐ rivaroxaban (XARELTO) ☐ warfarin (COUMADIN)	
Carolla Oltrasouria				C other	

Transient, persistent or fluctuating Transient, persistent or fluctuating symptoms of: hemibody sensory loss, symptoms of: Facial droop, visual disturbances (acute monocular unilateral arm or leg weakness, and visual loss, binocular diplopia or or speech disturbances hemivisual loss) YES YES Within 48 hours Within 48 hours Within 48 hours of Within 48 hours of NO-NOto 2 weeks of to 2 weeks of symptom onset symptom onset symptom onset symptom onset YES YES YES **VERY HIGH RISK HIGH RISK VERY HIGH RISK MODERATE RISK** Recommend required Urgent consult with on-call neurologist diagnostics on an outpatient basis at most within 2 weeks of As advised by neurologist, send patient to nearest CT-enabled presentation. See list of emergency department (see list of primary/tertiary stroke centres.) required diagnostics. Urgent brain imaging (CT) and non-invasive vascular imaging (CTA) should be completed as soon as possible within 24 hrs. Initiate the following before discharge Initiate the following before discharge from ED: from ED: • antiplatelet therapy (if r/o hemorrhage) antiplatelet therapy • stroke prevention clinic referral (if r/o hemorrhage) • stroke prevention clinic referral **Designated stroke centres:** Swift Current - Cypress Regional Hospital; Moose Jaw - Dr. F.H. Wigmore Regional Hospital; Estevan - St. Joseph's Hospital; Yorkton - Yorkton Regional Health Centre; Prince Albert - Victoria Hospital; North Battleford - Battlefords Union Hospital; Lloydminster-Lloydminster Hospital; Regina -

Regina General Hospital (designated tertiary centre); Saskatoon - Royal University

Hospital (designated tertiary centre)

Atypical sensory symptoms, anatomical Any TIA distribution not symptoms suggestive of stroke (eg patchy numbness and/or tingling) YES Greater than 2 Presents at any time weeks of symptom onset **LOWER RISK LOWEST RISK** Perform required Brain imaging and diagnostics on an timing based on outpatient basis within 1 clinical situation. **month** of presentation Consider neurology and refer to Stroke referral based on

Required Diagnostics for TIA

1. Brain Imaging (CT or MRI)

Prevention Clinic, See list

of required diagnostics

2. Non-invasive vascular imaging of neck and intracranial vessels (CTA EC/IC vessels, MRA EC/IC vessels or doppler ultrasound of neck vessels)

clinical judgment.

- 3. 12-lead ECG (assess for atrial fib)
- 4. Lab investigations (CBC, LYTES, PT/INR, creatinine, fasting lipid profile, Hg A1C, ALT, random blood sugar, troponin)