NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Markham Stouffville Hospital
Oak Valley Health

Hospital MRN #: _____

Patient Name (Last, First): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

Stroke Prevention Clinic Referral

Dr. David H. Kim, Stroke Neurologist

Markham Site Booking Line: (905) 472-7601
Fax: (905) 472-7621

Date:	Referring MD	Signature	MD Phone#

Additional Reports to:

Translator contact information for scheduling & accompaniment (name & number):

Reason for Referral:

_____

_____

_____

_____

_____

_____

Send patient to the nearest hospital IF:

TIA or stroke symptoms occurred within 48 hours.

OR

transient, fluctuating or persistent unilateral weekness (face, arm and/or leg), or speech disturbance have occured within the past 2 weeks

(reference: Canadian Stroke Best Practice Guidelines 2015)

Please include with this referral form:

- ☐ recent medical history
- ☐ recent bloodwork
- ☐ other pertinent test results

Patient must bring to the appointment:

- ☐ CD copy of any neuroimaging (CT or MRI) studies done outside of Markham Stouffville Hospital
- ☐ all medications
- ☐ a translator if patient does not speak English

PATIENT SHOULD ARRIVE 15 MINUTES BEFORE THE SCHEDULED APPOINTMENT TO REGISTER AND TRAVEL TO THE CLINIC WAITING ROOM.

MSH staff will contact your patient directly to schedule an appointment time.