

ST JAMES'S HOSPITAL TIA CLINIC REFERRAL

Name:	Date of Birth:												
Address:	Tel:												
GP Name:	Tel:												
Address:													
Date of Referral:													
History													
How long did the symptoms last?	Latest BP Reading:												
Were the following symptoms present?													
<ul style="list-style-type: none"> - Hemiparesis / Limb weakness - Visual Field Defect - Dysphasia - Headache - Loss of Consciousness 	<table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="padding: 0 10px;">Yes</th> <th style="padding: 0 10px;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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We would not recommend patients to drive for at least 4 weeks from date of stroke or TIA.