



**CONSULT NOTE  
FAX COVER**

Date: \_\_\_\_\_  
DD-MMM-YYYY

**SENDER**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Org. : \_\_\_\_\_

Fax: \_\_\_\_\_

Telephone: \_\_\_\_\_

**RECIPIENT**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Org. : \_\_\_\_\_

Fax: \_\_\_\_\_

Telephone: \_\_\_\_\_

This fax contains \_\_\_\_ pages total including the cover page.

**Notes (optional):**

\_\_\_\_\_

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# CONSULT NOTE FORM

Patient: \_\_\_\_\_

OHIP #: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Hospital: \_\_\_\_\_

MRN: \_\_\_\_\_

Ref MD: \_\_\_\_\_

Contact #: \_\_\_\_\_

Billing Code: \_\_\_\_\_

Date of Stroke: \_\_\_\_\_

Stroke Onset: \_\_\_\_\_ Time (HHMM) + day

Last seen normal: \_\_\_\_\_

Symptoms first recognized: \_\_\_\_\_

EMS Evaluation: \_\_\_\_\_

ER Arrival: \_\_\_\_\_

CT Scan: \_\_\_\_\_

Consultant paged: \_\_\_\_\_

Consult initiated: \_\_\_\_\_

Consult completed: \_\_\_\_\_

## HISTORY

## RISK FACTORS

<input type="checkbox"/> Hypertension	<input type="checkbox"/> DM	<input type="checkbox"/> ↑Lipids	<input type="checkbox"/> Smoking	<input type="checkbox"/> Neck Trauma
<input type="checkbox"/> CAD	<input type="checkbox"/> Valve Disease	<input type="checkbox"/> AF	<input type="checkbox"/> PVD	<input type="checkbox"/> Prior Stroke

Other Relevant Illnesses:

Current Medications:

Pre-stroke patient was on  antiplatelet agent, specify: \_\_\_\_\_  
 anticoagulant, specify: \_\_\_\_\_

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

MRN: \_\_\_\_\_

**EXAMINATION**

BP: _____ / _____	Pulse: _____	<input type="radio"/> Reg <input type="radio"/> Irreg	RR: _____	Temp: _____
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GCS: \_\_\_\_\_

Any evidence of recent bruising, trauma?

\_\_\_\_\_

Other relevant features?

\_\_\_\_\_

Neurological Exam (other):

\_\_\_\_\_

**NIH STROKE SCORE**

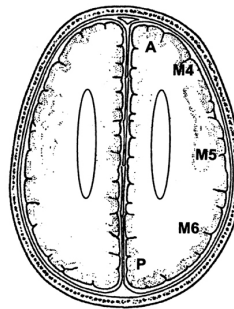
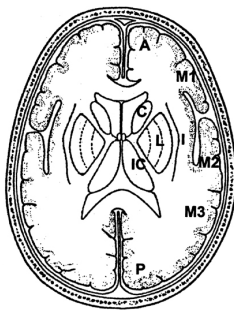
Item		Score
1 a.	Level of Consciousness	
1 b.	LOC Questions	
1 c.	LOC Commands	
2.	Best Gaze	
3.	Visual	
4.	Facial Palsy	
5 a.	Motor Arm - Left	
5 b.	Motor Arm - Right	
6 a.	Motor Leg - Left	
6 b.	Motor Leg - Right	
7.	Limb Ataxia	
8.	Sensory	
9.	Language	
10.	Dysarthria	
11.	Extinction and Inattention	
TOTAL		

**LAB RESULTS**

Glucose: _____	Platelets: _____	INR: _____	PTT: _____	Creat: _____
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**CT Scan:**  CTA  Multiphase  Perfusion

- Hemorrhage
- Hyperdense vessel
- LVO
  - Carotid T
  - Carotid L
  - M1
  - M2
  - M3



**ASPECT Score**

- Caudate \_\_\_\_\_
- Lentiform \_\_\_\_\_
- Insula \_\_\_\_\_
- IC \_\_\_\_\_
- MCA 1 \_\_\_\_\_
- MCA 2 \_\_\_\_\_
- MCA 3 \_\_\_\_\_
- MCA 4 \_\_\_\_\_
- MCA 5 \_\_\_\_\_
- MCA 6 \_\_\_\_\_
- TOTAL \_\_\_\_\_

Consultant's interpretation CT imaging:

\_\_\_\_\_

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

MRN: \_\_\_\_\_

**CONSULTANTS OPINION:**

Recommendation to treat with tPA: <input type="radio"/> Yes <input type="radio"/> No	If tPA not given, specify reason: _____	Document needle time: _____
Recommendation to send for EVT: <input type="radio"/> Yes <input type="radio"/> No	Name of hospital where patient was transferred for EVT: _____	

Time: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Contact Information**

Name: \_\_\_\_\_

Fax: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_

Org. : \_\_\_\_\_

[Download](#) Hospital Telephone & Fax

# DATA COLLECTION FORM

## DO NOT send to referring hospital

FAX to 416-603-5768 or  
EMAIL to frank.silver@uhn.ca

Date of Consult: \_\_\_\_\_

Age of Patient: \_\_\_\_\_

Referring Hospital: \_\_\_\_\_

Date of Stroke: \_\_\_\_\_

Telestroke MD: \_\_\_\_\_

Time (HHMM) + day

**CT Scan:** CTA Multiphase Perfusion

**Stroke Onset:**

Hemorrhage

Time: \_\_\_\_\_

Last seen normal: \_\_\_\_\_

Hyperdense vessel

ASPECT: \_\_\_\_\_

Symptoms first recognized: \_\_\_\_\_

LVO

NIHSS: \_\_\_\_\_

Carotid T

GCS: \_\_\_\_\_

Carotid L

M1

M2

M3

EMS Evaluation: \_\_\_\_\_

antiplatelet agent,  
specify: \_\_\_\_\_

ER Arrival: \_\_\_\_\_

anticoagulant,  
specify: \_\_\_\_\_

CT Scan: \_\_\_\_\_

Consultant paged: \_\_\_\_\_

**IV tPA:**

Yes  No Needle time: \_\_\_\_\_

Consult initiated: \_\_\_\_\_

If not given, why: \_\_\_\_\_

Consult completed: \_\_\_\_\_

**EVT:**

Yes  No

Hospital: \_\_\_\_\_

**Services Provided:**

**Comments (technical problems, concerns, feedback):**

Telestroke Consult Sent