Address: Post Code: Tel no. Home: Work: Mobile No:	Registered GP Name: Surgery address: Tel. no: Fax: e mail:

Sex:	Date of birth:	Hospital number:

Date of referral:	Referred by: GP ☐ ED ☐ Other ☐	Referring GP name (if different):

Date & time of onset of symptoms:

Date & time of first assessment by a clinician :

ABCD ^{2} SCORE Only assign one score per area (eg symptoms > 60 mins scores 2)		**Score**	**Patient Score**	**Patient Advice**
A = Age	> 60	1		• Explain FAST assessment to patient • He or she should not drive until he or she has been assessed at the hospital or clinic • If there was a witness to the event, that person should accompany the patient to the hospital or clinic • If the patient experiences any further event he or she should go immediately to A&E
B = BP	>140 Systolic and/or >90 Diastolic	1		
C = Clinical Features	Unilateral weakness	2		
	Speech disturbance w/o weakness	1		
D = Duration of Symptoms	> 60 minutes	2		
	10 – 59 minutes	1		
D = Diabetes	Diabetes	1		
Total ABCD ^{2} Please add the Patient score and enter total here				

Patient has crescendo TIA (2 or more TIAs in last 7 days): Yes ☐ No ☐

ABCD ^{2} = 1-3 - To be seen within 7 days, **ABCD ^{2} = 4-7 or crescendo TIA** - To be seen in next 24 hours

Clinical Features	**Present**	**Right**	**Left**
Hemiparesis / arm weakness	☐	☐	☐
Hemiparesis /leg weakness	☐	☐	☐
Loss of sensation	☐	☐	☐
Loss of vision	☐	☐	☐
Double vision	☐	☐	☐
Dysphasia / loss of speech	☐	Blood Pressure	
Loss of coordination	☐	/	
Duration of symptoms to complete resolution:			

Current Medication

Give patient 300 mgm Aspirin stat then daily unless contraindicated and provided all symptoms have resolved.

Ask patient to bring current medication / medication list to clinic.

Past medical history / Vascular Risk Factors			
Hypertension	☐	Hyperlipidaemia	☐
Isch. Heart Disease	☐	Smoker	☐
Heart failure	☐	Obesity	☐
Peripheral vascular disease	☐	Previous stroke/TIA	☐
Atrial fibrillation	☐	Migraine	☐
Diabetes	☐		

Is patient Aspirin Allergic / Aspirin intolerant Yes ☐ No ☐

History of Treatment / Other relevant information (please attach Patient Summary if available)

Patient requires transport for appointment: Yes ☐ No ☐

Please refer to attached guidelines and referral information

Please email to tia@uhs.nhs.uk
Office number :023 8120 5019