Beacon Hospital

TIA ASSESSMENT REFERRAL FORM

Complete for Patients with Acute Focal Neurological Symptoms lasting < 24 hours with NO Residual Neurological Symptoms or Signs

NB: Refer High Risk Patients for Urgent Same-Day Admission to local ED:

- **ABCD2 score greater than 3 (see below) or**
- **Patient has had more than one recent episode (DUAL TIA) or**
- **Known atrial fibrillation**

TIA Referral- GP Instructions

Please complete the **TIA Referral Form** and attach it to your **e-Referral** or email.
Healthlink: Select **"TIA Clinic"** from Beacon Hospital's Drop-Down Directory and send as normal.
If referral is **between Friday at 1100 and Monday morning at 0900**, please **direct patient to local ED**, as we are unable to accept referrals during this period

If unsure, please phone **0871038590** to discuss directly with consultants.

Surname: First Name:

DOB: Gender:

Tel. No: / Mobile No:

History of presenting complaint:

Date of symptom onset

Already taking anti platelet / anticoagulant Yes / No

Already taking anticoagulant Yes / No

Past medical history:

Beacon Hospital

TIA RISK STRATIFICATION SCORE (ABCD² SCORE)

Age		
≥60 years	1	
<60 years	0	
BP		
≥ 140/≥90	1	
< 140/<90	0	
Clinical Symptoms / Sign		
Hemiparesis	2	
Speech Disturbance only	1	
Other Symptons	0	
Duration		
≥ 60 minutes	2	
10 - 59 minutes	1	
< 10 minutes	0	
Diabetes		
Yes	1	
No	0	
	Total Score	

ABCD² Score 0 - 3: Refer to Beacon TIA clinic

ABCD² Score ≥ 4: Refer for admission to local ED