TIA
REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - NEUROLOGY •92 CAMPUS DRIVE, SUITE B, SCARBOROUGH, ME • (207) 883-1414

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND EXAM

Sudden onset of *transient* neurological dysfunction, usually lasting several minutes to a few hours, including weakness or numbness on half of the face/body, difficulty speaking or understanding speech, partial loss of vision or double vision, dizziness, imbalance, difficulty walking.

The neurological exam should be normal or have no new findings following the episode. Signs and symptoms that improved › 24 hours from onset are more likely to be associated with stroke on imaging.

SUGGESTED PREVISIT WORKUP

Patients should be referred to the ED if symptoms occurred within the last 72 hours, or have not completely resolved.

Imaging: MRI brain, CT head if unable to do MRI; CTA or MRA head and neck preferred, carotid ultrasound only if unable to do either CTA/MRA

Cardiac Evaluation as indicated: TTE with bubble study and EKG; Troponin and Telemetry while hospitalized

LABS:
Fasting lipid panel, fasting blood glucose or HbA1c, CBC, CMP, and consider PT/INR, aPTT, and urinalysis in appropriate cases

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND EXAM

Symptoms and exam as outlined in the "high risk" column; however, symptoms occurred › 72 hours ago, the patient has already completed a work up for TIA, and appropriate secondary stroke prevention measures are in place.

SUGGESTED WORKUP

Results for Imaging, Cardiac Evaluation, and Labs from the "high risk" column should be provided, or promptly ordered if necessary, by the referring provider

Continue secondary stroke prevention measures. Neurologist can help determine if there is a need for more specialized testing, such as TEE, prolonged cardiac monitoring, or evaluation for blood coagulation disorders.

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND EXAM

Symptoms inconsistent with those in the "high risk" column, including isolated sensory complaints without objective findings on exam or prior diagnostic testing, are likely to be caused by another process, such as migraine aura, benign paroxysmal -positional vertigo, orthostasis, adverse effects of medication, delirium, etc., especially in the setting of a negative stroke work-up in the past.

SUGGESTED MANAGEMENT

Ensure appropriate primary stroke and cardiovascular prevention measures are in place.

Consider potential causes of the symptoms, and pursue further evaluation as indicated.

CLINICAL PEARLS

- Transient neurological symptoms that last only seconds are unlikely to be TIA.
- Paresthesia isolated to the face or part of a limb , slurred speech without facial droop or other deficits and vertigo without any other deficits, are unlikely to be TIA and alterative explanations should be considered.
- Actual reports of diagnostic testing (imaging, cardiac evaluation, labs) are strongly preferred over second hand reports of results.
- Please make sure actual images are available for review on IMPAX or disc prior to the patient's appointment.

Maine Medical PARTNERS

Reviewed by Christopher Cummings, MD

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