

# EMERGENCY TRANSFER LETTER: ACUTE NEUROLOGICAL DEFICIT

**Date:** [Date]

**Time of Assessment:** [Time]

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**To:** Emergency Department Triage / Stroke Team

**Facility:** [Receiving Hospital Name]

## RE: Patient Identification

Name: [Patient Full Name]

DOB: [Date of Birth]

ID Number: [Health ID/MRN]

## 1. Chief Complaint & Timeline

Presenting Symptom: [e.g., Facial droop, hemiparesis, aphasia]

Last Known Well (LKW) Time: [Insert Time/Date]

Onset of Symptoms: [Insert Time/Date]

## 2. Clinical Findings

Blood Pressure: [BP] | Heart Rate: [HR] | SpO2: [%]

Blood Glucose Level: [BGL]

Neurological Exam: [e.g., Left-sided weakness 2/5, slurred speech, GCS score]

## 3. Immediate Interventions Provided

Oxygen administered

IV Access established (Location: [ ])

Aspirin/Anticoagulants given/held: [Details]

Other: [Details]

## 4. Medical History & Medications

Relevant History: [e.g., Hypertension, Atrial Fibrillation, Diabetes, Previous Stroke]

Current Anticoagulation: [e.g., Warfarin, Apixaban, None]

## 5. Referring Clinician Contact

Name: [Doctor Name]

Clinic: [Clinic Name]

Phone Number: [Contact Number]

**Note:** Please notify the Stroke Coordinator/Neurologist on call immediately upon patient arrival.