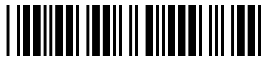
DIAGNOSTIC VASCULAR LAB TEST REQUISITION
Abbotsford Regional Hospital



Form ID: PMVC107224C Rev: March 18, 2020

General Day Care, Fraser Wing, 3rd floor
Phone: (604) 870-7523

Complete form and fax to ARH Diagnostic Vascular Lab at (604) 851-4766

DATE OF REQUEST: ______________________________

NAME: ____ BIRTHDATE: ________________________

GENDER: __________ MEDICAL (PHN): ____________________ PHONE: ____________________

INFECTION PRECAUTION: ☐ MRSA ☐ CPO ☐ Candida auris (C.auris)

Non-Invasive Testing:

☐ Arterial Test both legs (ABI), **with** treadmill exercise permitted ☐ Add toe pressures

☐ Arterial Test both legs (ABI), **without** treadmill exercise ☐ Add toe pressures

☐ Other (specify) ____

Note: If patient cannot stand up with assistance, you need to arrange patient transfer both ways.

Patient instructions/education available for print at: https://patienteduc.fraserhealth.ca/search/results/397536

Indications for Testing:

☐ Claudication (external calf or thigh pain) ☐ Ischemic ulceration/gangrene ☐ Ischemic rest pain

☐ Venous disease ☐ Other: ______________________________

☐ Previous vascular surgery – Details: ____

History:

☐ Coronary artery disease ☐ Hypertension ☐ Angina ☐ Diabetes ☐ COPD/Emphysema

☐ Renal disease ☐ Cerebrovascular disease ☐ Other History: __________________________

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Request Vascular Surgery Consult if ABI/TBI abnormal: ☐ Yes ☐ No

Referring Provider: ____________________________ Signature: ____________________________

MSP #: ____________________________ Phone: ____________________ Fax: ____________________

Copy to other Provider: ____ Fax: ____________________

Office use only: Date Booked: ____