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DIAGNOSTIC VASCULAR LAB TEST REQUISITION
Abbotsford Regional Hospital

Form ID: PMVC107224D Rev: June 25, 2021 Page: 1 of 1

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: _____

_____

Referring Provider: _____ Signature: _____

MSP #: _____ Phone: _____ Fax: _____

Copy to other Provider: _____ Fax: _____

Office use only: Date Booked: _____