



DIAGNOSTIC VASCULAR LAB TEST REQUISITION
Abbotsford Regional Hospital



Form ID: PMVC107224C

Rev: March 18, 2020

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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: _____

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: _____