MEDIGROUP CARDIO+

Medigroup Cardio+
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Ankle-Brachial Index (ABI) Test Requisition

Patient name: _____ DOB: _____

MH #: _____ PHIN #: _____

☐ Male ☐ Female ☐ Other _____ Email: _____

Address: _____

Phone: home/cell _____ work _____

Referring provider name: _____

Clinic/hospital: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

INDICATION FOR ABI
☐ PAD/PVD
☐ Edema
☐ Claudication
☐ Vascular screening (high risk individual) - DM2/dyslipidemia/HTN/smoking/age>50
☐ Assessment for safe use of compression therapy
☐ Assessment for wound healing potential
☐ Other: _____

MEDICAL HISTORY
☐ no active medical conditions

ACTIVE MEDICATIONS
☐ no medications

DRUG ALLERGIES
☐ no known drug allergies

All test results will be reviewed by our vascular specialists