



**MAINE DOCTORS OFFICE  
REQUISITION FOR  
TEST / CONSULT  
FAX REQUEST TO 207- 490-1758  
Telephone Number 207-324-5968**

Name of the patient: \_\_\_\_\_ DOB \_\_\_\_\_

Patient's Contact telephone number(s): \_\_\_\_\_

<input type="checkbox"/> Consult with Dr. Abraham	<input type="checkbox"/> Ankle Brachial Index (PAD Net)
<input type="checkbox"/> Consult with Dr. Bhargava	<input type="checkbox"/> Ambulatory Blood Pressure Monitor
<input type="checkbox"/> Consult with Dr. Kaufman	<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> Consult with Dr. Rowden	<input type="checkbox"/> Electrocardiogram
<input type="checkbox"/> Consult with Dr. Sharma	<input type="checkbox"/> Compression garment / Stockings
<input type="checkbox"/> Cardiac Stress Test Consult	<input type="checkbox"/> Holter Monitor
<input type="checkbox"/> Colonoscopy/ Endoscopy Consult	<input type="checkbox"/> Impedance Cardiography
<input type="checkbox"/> Heart Failure Management Consult	<input type="checkbox"/> Home Sleep Study
<input type="checkbox"/> OMT/ Pain Management Consult	<input type="checkbox"/> Photo Dynamic Therapy for AK
<input type="checkbox"/> Skin Screening Consult	<input type="checkbox"/> Video Capsule Endoscopy

Reason for consultation or test:	Requesting Provider:
----------------------------------	----------------------

**For MDO office use only**

Appointment date: \_\_\_\_\_ Time: \_\_\_\_\_

<input type="checkbox"/> Insurance Checked	<input type="checkbox"/> Referring office notified of visit date
<input type="checkbox"/> Prior Authorization Checked	<input type="checkbox"/> Referring office provided with final report
<input type="checkbox"/> Records Retrieved	