Patient Name: ………………………………............................................................. D.O.B: …………….....……………………………………….

Address: …………………………………………………………………………………………………………………………………………………………………………

Telephone Number: ………………………………………….……………………………………………………………………………………………………………

E-mail: ………………………………………………………………………………………. Insurance provider: …………………………………………………..

Referring Doctor: ……………………………………………………………………………………………………………………………………………………………

Email address for Results: ………………………………………………………………………………………………………………………………………………………..

Mobility Issues/Special Requirements: ……………………………………………………………………………………………………………………………

|  |  |
| --- | --- |
| **Oesophageal and Pharyngeal Physiology testing:**High-Resolution Oesophageal Manometry-Z24-Hour Ambulatory Oesophageal pH-Impedance24-hour Ambulatory LPR pH-Impedance High Resolution Pharyngeal Manometry-ZBiofeedback for Rumination/Supragastric Belching | **Gastroduodenal testing:**Electrogastrogram (EGG)Gastric Alimetry C13 Gastric Emptying Helicobacter Pylori Breath Test Gastric Acid Output Study  |
| **Hydrogen, Methane and HS Breath testing:**Lactulose (SIBO) HMBT Glucose (SIBO) HMBT Lactose intolerance HMBT Fructose intolerance HMBTHydrogen Sulphide Breath Testing  | **Lower Gastrointestinal Physiology testing:**High-Resolution Anorectal ManometryEndo-anal UltrasoundPudendal Nerve Terminal Motor Latencies (LDN only) Evacuation Proctography (LDN only)Whole-Gut Transit (Radio-opaque Markers) (LDN only)**Also:**Biofeedback for Evacuatory Dysfunction / IncontinencePercutaneous Tibial Nerve Stimulation (PTNS) (LDN only) |

Clinical Indication…………………………………………………………………...................................................................................................................

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**PLEASE CIRCLE THE ANSWERS:**

Does the patient have Diabetes?

**YES NO**

Has the patient had gastrointestinal surgery?

**YES NO**

Has the patient a history of Cardio-Respiratory disease?

 **YES NO**

Has the patient been prescribed and Anticoagulants or Antiplatelets?

**YES NO**

Has the patient any of these IFDs: Hep B/C, HIV, CDIF, MRSA, TB?

**YES NO**

Has the patient any allergies?

**YES NO**

Has the patient ever been informed that they are at increased risk of vCJD for Public Health purposes?

**YES NO**

Has the patient been diagnosed with vCJD or a similar illness (either definite, possible or probable)?

**YES NO**

Has the patient any symptoms compatible with vCJD?

**YES NO**

Does the patient require an interpreter?

**YES NO**

Is the patient fit for physiological diagnostic testing?

**YES NO**

Consent initiated?

**YES NO**

Additional Relevant Information? ……………………………………………................................................................................

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