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-Z  24-Hour Ambulatory Oesophageal pH-Impedance  24-hour Ambulatory LPR pH-Impedance  High Resolution Pharyngeal Manometry-Z  Biofeedback 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 HMBT  Hydrogen Sulphide Breath Testing | **Lower Gastrointestinal Physiology testing:**  High-Resolution Anorectal Manometry  Endo-anal Ultrasound  Pudendal Nerve Terminal Motor Latencies (LDN only)  Evacuation Proctography (LDN only)  Whole-Gut Transit (Radio-opaque Markers) (LDN only)  **Also:**  Biofeedback for Evacuatory Dysfunction / Incontinence  Percutaneous Tibial Nerve Stimulation (PTNS) (LDN only) |

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

……………………………………………………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………

**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? ……………………………………………................................................................................

…………………………………………………………………………………………………………………………………………………………………………