GI PHYSIOLOGY PROCEDURE REQUEST FORM

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:		Gastroduodenal testing:	
High-Resolution Oesophageal Manometry-Z	☐	Electrogastrogram (EGG)	☐
24-Hour Ambulatory Oesophageal pH-Impedance	☐	Gastric Alimetry	☐
24-hour Ambulatory LPR pH-Impedance	☐	C13 Gastric Emptying	☐
High Resolution Pharyngeal Manometry-Z	☐	Helicobacter Pylori Breath Test	☐
Biofeedback for Rumination/Supragastric Belching	☐	Gastric Acid Output Study	☐
Hydrogen, Methane and HS Breath testing:		**Lower Gastrointestinal Physiology testing:**	
Lactulose (SIBO) HMBT	☐	High-Resolution Anorectal Manometry	☐
Glucose (SIBO) HMBT	☐	Endo-anal Ultrasound	☐
Lactose intolerance HMBT	☐	Pudendal Nerve Terminal Motor Latencies (LDN only)	☐
Fructose intolerance HMBT	☐	Evacuation Proctography (LDN only)	☐
Hydrogen Sulphide Breath Testing	☐	Whole-Gut Transit (Radio-opaque Markers) (LDN only)	☐
		Also:	
		Biofeedback for Evacuatory Dysfunction / Incontinence	☐
		Percutaneous 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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