core
SPECIALIST GROUP

Manometry and pH Testing Request Form

PATIENT DETAILS

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____/_____/_____/ mm / dd / yyyy Contact Telephone: _____

Address: _____ Suburb: _____ Post Code: _____

PLEASE TICK THE TESTS REQUIRED

☐ Oesophageal manometry
☐ Oesophageal manometry + 24 Hr pH study

SYMPTOMS

☐ Dysphagia
☐ Waterbrash
☐ Atypical chest pain
☐ Cough
☐ Heartburn
☐ Regurgitation
☐ Throat Symptoms
☐ Reflux

CLINICAL DETAILS

Has the patient had any previous upper GI surgery? _____

_____

PREVIOUS TESTS DONE? ** These are a requirement prior to Manometry testing **

*Contrast Swallow (Required)	☐ Yes / No ☐	If yes – Please attach results
*Gastroscopy (Required)	☐ Yes / No ☐	If yes – Please attach results
Other. Eg. CT, Nuclear Med reflux study	☐ Yes / No ☐	If yes – Please attach results

REFERRING DOCTOR

Name: _____ Provider Number: _____ Date:_____/_____/_____/

Clinic Address: _____

* pH studies will be performed off PPI for 1-2 weeks unless otherwise specified

Our reception staff will contact the patient to arrange the procedure booking. Please attach all pathology, imaging and endoscopy results with this referral.
PLEASE FAX REFERRAL TO **07 35408141.**

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