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

Address: …………………………………………………………………………………………………………………………………………………………..

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

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

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

Address for Results: …………………………………………………………………………………………………………………………………………

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

High Resolution Oesophageal Manometry and Impedance

24 Hour Ambulatory Oesophageal pH and Impedance

High Resolution Ano-Rectal Manometry

Small Bowel Physiology (SmartPill) Study

Gastric Emptying Breath Test

Hydrogen and Methane Breath Test SIBO (Lactulose)

Lactose intolerance (Lactose)

Fructose intolerance (Fructose)

Other (please specify: \_\_\_\_\_\_\_)

Helicobacter Pylori Breath Test

Biofeedback for Evacuatory Dysfunction / Incontinence

Endo-anal Ultrasound

Evacuation Proctography (available in London only)

Pudendal Nerve Study (available in London only)

Whole-gut transit study (radio-opaque markers) (available in London only)

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

**PLEASE CIRCLE THE ANSWERS:**

Does the patient have Diabetes?

**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?

-----------------------------------------------------------------------------------------------------------------------------------------------------------