Motility
10th Floor / Gastroenterology clinic
200 Elizabeth St. Toronto, ON
Tel: 416 340-3234 or 3901
Fax: 416 340-3681

Referral Form for Esophageal Manometry & 24-Hour Ambulatory pH Study

Patient Name:________________________________

Email: ____________________________________

Sex: M/F DOB (D/M/Y): ____________

Referring Doctor: ___________________________

Phone # _______________**Fax#** __________________

Family Doctor: ______________________________

Date: ______________________________________

Patient demography: address, phone #, OHIP, MRN(if known)

PRIMARY REASON FOR REFERRAL:

Pre-fundoplication ____
Post-fundoplication ____
Dysphagia/Odynophagia ____
NCCP____
Systemic Disease______
Proven GERD poor Rx response_____
Atypical GERD_____
Respiratory_____
Globus_____
Other:____

TEST TO BE DONE: □ on treatment, or □ off treatment (PPI'S, H2, RA'S, Prokinetics, Other)

Primary Symptoms:____

____

Background and related symptoms:____

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Specific question being asked: ____

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(For external use only)