Dartmouth-Hitchcock
MEDICAL CENTER

Phone: (603) 650-5215
Fax: (603) 650-5225

Gastroenterology Motility Laboratory

Order Form

Referring Provider: _____

Office Phone: _____

Office Fax: _____

Please note: An appointment secretary will contact your patient to schedule an appointment. Please provide daytime phone where patient can be reached between 8am – 5pm.

Patient Name: _____

DOB: _____

DHMC MR#: _____

Daytime phone: _____
(between 8am – 5pm)

IMPORTANT – PLEASE COMPLETE

Diagnosis/reason for procedure: _____

_____

Question(s) to be answered: _____

_____

Special Needs/Requirements (please note if your pediatric or adult patient requires any assistance for this test):

_____

Procedure(s) Ordered

❑ **BRAVO Wireless 48 hour pH Capsule** (preferred test to diagnose GERD)
Note: BRAVO cannot be performed in patients with neurostimulators, esophageal varices or cardiac pacemakers. Your patient should NOT have an MRI for at least ONE MONTH after procedure is performed.

❑ **Impedance pH Testing**: to measure both acid and non-acid reflux.

Required: Please answer the following questions for BRAVO or Impedance pH studies:

❑ To be done ON acid suppressing medication (list medication and dose): _____

❑ To be done OFF medication: PPI's, H2RAS need to be held 7 days prior; no antacids 24 hours prior to testing.

1. Has patient had a prior upper endoscopy (EGD) procedure (within the last 2 years)? ❍ Yes ❍ No
2. Has patient had an esophageal manometry (within the last year)? ❍ Yes ❍ No
   Note: If patient has not had an upper endoscopy or esophageal manometry, an esophageal manometry will be scheduled at time of Impedance pH study or BRAVO capsule placement to ensure proper placement.
3. Does this procedure need to be coordinated with an upper endoscopy (EGD)? ❍ Yes ❍ No
4. Is this appointment needed prior to surgery? ❍ Yes ❍ No If yes, when is surgery date? _____

❑ **Esophageal Manometry**

❑ **Anorectal Manometry:** + Sensory Testing ❑ Also with balloon expulsion (for constipation)

❑ **Electrogastrogram or Antroduodenal Manometry:** prior consultation with DHMC **required**

No test can be scheduled unless a recent office note is sent with this form. Please include the upper endoscopy report if applicable. **Note that sedation is not given for any procedure in the motility lab.**

Referring physician's signature (required): _____ **Date:** _____