GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
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Motility and pH Testing Request Form (Please attach patient demos)

_____/_____/_____
Patient Name DOB Primary Phone

_____
Requesting Provider Phone Fax

Please send this completed form to our office with the complete patient demographics, the most recent history and physical (H+P), and any other relevant medical testing or imaging.

Phone: 401-943-1303 Fax: 401-946-8480

Indicate the test being performed:

- ☐ High Resolution Esophageal Manometry
- ☐ 48 Hour Bravo Wireless Capsule pH Monitoring
- ☐ 96 Hour Bravo Wireless Capsule pH Monitoring
- ☐ EndoFlip

Indicate the reason for the test:

- ☐ Dysphagia
- ☐ Atypical chest pain (cardiac testing should have been performed already)
- ☐ Heartburn
- ☐ Regurgitation
- ☐ Belching
- ☐ Supra-esophageal reflux symptoms:
  - Pre-operative evaluation
- ☐ Other:_____

- If pH testing is being requested, is the study going to be done **ON** or **OFF** acid suppression medications?

  If on medications, what medication/dosage:_____

- **Does the patient have any other *major relevant medical problems?*:**_____

  _____

- **Results of prior pertinent studies?:**

  Barium Esophagram:_____

  Endoscopy Results:_____

  Prior motility testing results at an outside facility:_____

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Cranston, RI 02920
(401) 943-1300

360 Kingstown Road - Suite 202
Narragansett, RI 02882
(401) 789-1860

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