



GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

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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 reason for the test:

Indicate the test being performed:

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

- ☐ 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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