The St George Swallow Centre
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St George Hospital

University of New South Wales

REQUEST FOR OESOPHAGEAL FUNCTION STUDIES

PATIENT NAME:…….

ADDRESS:…….

……...……..

MEDICARE NUMBER:……**MRN**:……

DOB:…… **SEX:**…..M / F

TELEPHONE: ……**EMAIL**:……

Study Requested: (√)

- ☐ Oesophageal manometry
- ☐ Ambulatory oesophageal pH monitoring
  (NB: Cease PPIs or H_2RAs at least 7 days prior)

Patients routinely bulk billed for these tests

Indication/purpose of this referral:

…….

…….

…….....

Additional report(s) to:

……...

Referring doctor's name, address, fax, email & provider number:

Referring doctor signature:……..Date:…….....

Fax this request to: (02) 9113 3993Or Email to: seslhd-stgeorge-gastroliver@health.nsw.gov.au