Banner Health®

SWALLOWING AND REFLUX ORDER FORM

Requesting Physician: ____________________________ Specialty: ____________________

Office Phone: ______________ Fax: ______________ Other Providers to receive report: ________________

Patient Information:

Patient Name: ____________________________ Date of Birth: ____________________

Patient Email: ____________________________ Gender: ❑ **Male** ❑ **Female**

Cell Phone: ______________ Work/Home Phone: ______________ **Please** FAX notes & reports.

Clinical Question: (Please indicate diagnoses codes to the highest level of specificity)

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Reason for referral:

Prior foregut surgery? ____________________ (Type) Prior Tx for dysphagia? ____________________ (Type)

❑ **Dysphagia** - mechanical obstruction excluded on EGD or barium esophagram? Order ESO-HRM only.

❑ **GERD** ______ GERD confirmation? Order ESO-HRM and pH-Z OFF PPI's.
______ GERD Medication Optimization? Order ESO-HRM and pH-Z ON PPI's.
______ Laryngopharyngeal Reflux (LPR)? Oder ESO-HRM and pH-Z OFF PPI's.

❑ **Atypical Chest Pain.** Order ESO-HRM and pH-Z OFF PPI's.

❑ **Pre-Op Testing** for Anti-Reflux Surgery. Order ESO-HRM and pH-Z OFF PPI's (to confirm diagnosis)

❑ **Digestive Institute Provider Consultation**

Procedure(s) Requested:

❑ ESO-HRM = High-resolution esophageal manometry with impedance (to check motility & place catheter).

❑ pH-Z = 24 hour Dual Sensor pH-impedance testing (to evaluation for acid, weak acid and non-acid reflux)
Standard: ❑ OFF PPI x 10 days; ❑ ON PPI = to confirm meds working, or assess symptoms
(BRAVO 48-96 hr wireless capsule available for those unable to tolerate pH catheter. Call to discuss!)

Testing Center:
Banner – University Medical Center Phoenix
1111 E. McDowell Rd.
Phoenix, AZ 85006
Ph: 602.839.4206

Clinic:
Digestive Institute
1441 N. 12th St.
Phoenix, AZ 85006
Ph: 602.521.5180

FAX this completed form to 602.839.6513 or email to GIscreening@BannerHealth.com. We will schedule your patient.

Our dedicated team performs and interprets these state-of-the-art esophageal studies. We will notify your office with your patient's procedure date, FAX you the results after the procedure, and mail you a hard copy of the full report. We are always happy to discuss findings with you.

Requesting Physician (sign): ____________________________ Date/Time: ____________________

Prior Auth. #: ________________ ❑ PA Not Required: (Center Approved ________________________)

Thank you for your referral!

2026 Physician Orders