

**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)
_____**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: 602.839.9043

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!

