

Hamilton Health Sciences

PROCEDURE REFERRAL FOR

• Esophageal Manometry

- 24 hr pH Monitoring • 24 hr pH Impedance
- Anorectal Manometry • Anorectal Biofeedback

DATE: (yyyy/mm/dd) _____

REFERRING PHYSICIAN:

Printed Name _____

Signature _____ OHIP Billing Number _____ Fax: _____

Address _____ Phone: _____ (ext) _____

Patient's Last Name

First Name

Address – Street

City

Postal Code

Telephone: ()

Ext.

Cell Phone: ()

Date of Birth
(yyyy/mm/dd)

Age

Gender

☐ M

☐ F

HIN

Family Physician

PROCEDURE REQUESTED (Check all applicable)

TEST:

INDICATION:

INSTRUCTIONS:

☐

Esophageal
manometry

☐

Dysphagia*/ Odynophagia*

☐

Chest pain

☐

GERD: pre or post fundoplication.

* Oropharyngeal dysphagia has been
ruled out prior to the referral

☐

Discontinue prokinetics (domperidone,
metoclopramide, prucalopride) 72h prior
to the test

☐☐

24 hour
pH-metry

☐

Suspected GERD (HB, chest /
epigastric pain)

☐

Respiratory Sx

Discontinue: - PPI 7 for days

- H2 RA for 3 days

- prokinetics for 3 days

☐

24 hour
pH + Impedance

☐

Refractory GERD (to assess
efficacy of PPI)

☐

Suspected non-acidic reflux

☐

Pediatric GERD

This test is being performed while on
antisecretory medication

☐

Anorectal
Motility

☐

Incontinence

☐

Constipation

☐

Rectal pain

☐

Other _____

☐

Biofeedback

☐

Incontinence

☐

Constipation

Patients must have had prior
ano-rectal motility test at HHS

*** Please fax results from any of the above tests which have already been done, with this referral ***

Current Medication List: ☐ Faxed with Referral

Current Allergy List: ☐ Faxed with Referral

Please fax legibly completed form and accompanying documentation,
including most recent consultation letter relevant to this request, to 905-526-0594.

Incomplete referrals **WILL NOT BE PROCESSED**

If you require any clarification, please contact the Motility Lab at 905-521-2100 X – 76691



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Referrals (Sovera document type)