



MELBOURNE
GASTRO OESOPHAGEAL
SURGERY

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Oesophageal Physiology Request

Please write in clear block letters.

Patient name: _____

Date of birth: _____

Address: _____

Phone: _____

Please mark the requested test(s):

- Oesophageal Manometry
- Oesophageal Manometry & 24 hour pH studies **OFF** acid suppression
- Oesophageal Manometry & 24 hour pH studies **ON** acid suppression

Indications & clinical details:

Anti-acid therapy or relevant medications: _____

Clinical images attached (if applicable):

Referrer: _____ Provider No: _____

Address (for sending report): _____

Contact number: _____

Signature: _____ Date: _____

Important Information:

- Once the referral is **received** patients will be contacted to organise an appointment and will be provided with further information and instructions.
- **OFF** Acid suppression: Medication is ceased 5 days prior to test.
- **Fasting time:** 4 hours
- Please allow **3 weeks** from study date for the report.