



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.