



JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

DIVISION OF DIGESTIVE DISEASES
4940 Eastern Avenue

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MOTILITY TESTING ASSESSMENT / REFERRAL FORM

JHBMC MR # _____ Out Pt ___ In Pt ___ Referral Date _____ Appointment Date _____

(Print all Information)

Patient Name _____ DOB _____ AGE _____ M / F

Referring Physician _____ Signature _____ Phone _____

Primary Care Physician _____ Phone _____

Insurance _____ Insurance ID# _____ Pre Approval Required? Y ___ N ___

PRESENTING COMPLAINTS: (Please check all pertinent symptoms and circle the primary complaint when possible)

<u>GASTROESOPHAGEAL</u>	<u>GASTROINTESTINAL</u>	<u>COLONIC / ANORECTAL</u>
<input type="checkbox"/> Chest Pain (Upper / Lower / Both)	<input type="checkbox"/> Abdominal Pain (LUQ, RUQ, Mid)	<input type="checkbox"/> Abdominal Pain (LLQ, RLQ, Mid)
<input type="checkbox"/> Dysphagia (High/Low Solid/Liquid)	<input type="checkbox"/> Nausea (<input type="checkbox"/> X/ week)	<input type="checkbox"/> Rectal Pain (<input type="checkbox"/> X/ week)
<input type="checkbox"/> Heartburn / Reflux (<input type="checkbox"/> X/ week)	<input type="checkbox"/> Vomiting (<input type="checkbox"/> X/ week)	<input type="checkbox"/> Constipation (<input type="checkbox"/> BM's / week)
<input type="checkbox"/> Esophagitis / Barrett's	<input type="checkbox"/> Early Satiety	<input type="checkbox"/> Straining (<input type="checkbox"/> %)
<input type="checkbox"/> Regurgitation (<input type="checkbox"/> X/ week)	<input type="checkbox"/> Weight Loss: _____ lbs.	<input type="checkbox"/> Incomplete Evacuation (<input type="checkbox"/> %)
<input type="checkbox"/> Cough	<input type="checkbox"/> Gastrointestinal Reaction to Milk	<input type="checkbox"/> Diarrhea (<input type="checkbox"/> BM's/ week)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal Reaction to Food	<input type="checkbox"/> Fecal Incontinence (# <input type="checkbox"/> / month)
<input type="checkbox"/> Voice Changes	<input type="checkbox"/> Distention / Bloating (<input type="checkbox"/> X/ week)	<input type="checkbox"/> Urinary Incontinence (# <input type="checkbox"/> / month)
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

REQUESTED PROCEDURES: (Check procedures and circle time frame desired) **URGENT** **WITHIN ONE WEEK** **NEXT AVAILABLE**

<u>GASTROESOPHAGEAL</u>	<u>COLONIC / ANORECTAL</u>
<input type="checkbox"/> Esophageal Motility Study	<input type="checkbox"/> Anorectal Motility Study
<input type="checkbox"/> **24 Hour pH on medications	<input type="checkbox"/> Biofeedback (Incontinence)
<input type="checkbox"/> **24 Hour pH off of medications	<input type="checkbox"/> Biofeedback (Constipation)
<input type="checkbox"/> Gastric Motility	<input type="checkbox"/> Other
<input type="checkbox"/> Antroduodenal Motility	
** DUAL ESOPHAGEAL PLACEMENT WILL BE USED UNLESS OTHERWISE REQUESTED.	SHADED AREAS ARE TESTS NOT CURRENTLY AVAILABLE

Patient Address: _____

Home Phone: _____

Work Phone: _____

Allergies: _____

Special Instructions: _____