Division of Gastroenterology, Motility
Department of Medicine in the College of Medicine

Scheduling phone: 352.265.3636
Scheduling fax: 352.627.4074

GI Motility Order

Please complete patient information below, or attach patient demographic information prior to fasting.

Patient's Name – Last: _____ First: _____ MI: _____

DOB: _____ MR#: _____

Home #: _____ Work #: _____ Cell #: _____

Referring Provider: _____ Office Phone #: _____

HIGH RESOLUTION ESOPHAGEAL MANOMETRY

☐ High Resolution Esophageal Manometry

☐ Indication: _____

☐ **REQUIRED** Records: last EGD or Fluoroscopy report (Esophagram)

AMBULATORY pH STUDIES

☐ 24-hour pH with Impedance* ☐ On PPI ☐ Off PPI

☐ Indication: _____

☐ **REQUIRED** Records: last EGD or Fluoroscopy report (Esophagram)

☐ 48-hour Bravo with EGD ☐ On PPI ☐ Off PPI

☐ Indication: _____

☐ Nickel allergy ☐ YES ☐ NO

HIGH RESOLUTION ANORECTAL MANOMETRY WITH BALLOON EXPULSION

☐ Indication: _____

ADDITIONAL RECORDS

For patient safety reasons, please include the following information on your patient:_____

- ☐ Most recent EGD/Colonoscopy reports and biopsies
- ☐ List of medications
- ☐ Surgical and medical history
- ☐ Pertinent CT Scan/MRI/imaging tests
- ☐ Full anticoagulation
  - ☐ YES ☐ NO
- ☐ Dual antiplatelet therapy (ASA and Plavix)
  - ☐ YES ☐ NO

SMART PILL *(Wireless Motility Capsule)*

☐ Indication: _____

☐ Required Records: surgical and medical history

* Contraindicated in patients with implanted electromechanical device or concerns for intestinal obstruction

The following information is required before a Smart Pill order can be placed:

- ☐ Food allergy
  - ☐ YES ☐ NO (*If yes,* please attach list)
- ☐ Implanted or portable electromechanical device
  - ☐ YES ☐ NO
- ☐ Physiological/mechanical GI Obstruction, strictures or fistulas
  - ☐ YES ☐ NO
- ☐ Swallowing disorders including severe dysphagia to food or pill
  - ☐ YES ☐ NO
- ☐ GI surgery within last three months
  - ☐ YES ☐ NO
- ☐ Bezoar or history of bezoar
  - ☐ YES ☐ NO
- ☐ Crohn's disease or diverticulitis
  - ☐ YES ☐ NO
- ☐ A scheduled MRI in the next 2 weeks
  - ☐ YES ☐ NO

_____ _____ _____ _____

Ordering Physician Signature *(required)* MD# Date Time

_____

Ordering Physician Print Name

Patient Name: Patient Identification #:

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