



Consultant Referral Form

Patient Details					
Name			MRN		
Address			Email		
			DOB		
			Phone Number		
Preferred Clinic	Sandyford		Galway		Naas

Procedure Required (Tick as Required)			
Small Intestinal Bacterial Overgrowth (SIBO)		UBT	
Lactose Malabsorption		UBT Post Treatment	
Fructose-Sorbitol Malabsorption		Fructose Malabsorption	
Sorbitol Malabsorption		Sucrose Malabsorption	

Symptom(s) / Diagnosis(es)							
Bloating		Crohn's Dx		OGD	Yes		No
Diarrhoea		Ulcerative Colitis		Result			
Constipation		H.Pylori					
Altered Bowel Habit		Coeliac Dx					
Flatus		Pancreatic Dx		Colonoscopy	Yes		No
Fullness		IBS		Result			
Cramps		Gastritis					
Belching		Adhesions					
Gastric Reflux		Bariatric Surgery		Dietary Response			
Fatigue		GIT Surgery		Positive Response			
Halitosis		Diverticular Dx		Moderate Response			
Oesophagitis		Barretts		No Response			

Referring Consultant				
Name			Phone	
Address			Fax	
			Email	
Referral Date			Signed	

Please forward all postal correspondence to our Sandyford address. Alternatively, completed forms can be faxed to (01) 5242593 or emailed to info@gastrolife.ie