GastroLife

Hydrogen, Methane and Helicobacter Pylori Breath Testing Clinic

GP 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 GP			
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

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