UNC Gastroenterology Motility Lab Referral
UNC Hospitals
101 Manning Drive, Chapel Hill, NC 27514
Local: (919) 843-7200 | Fax (919) 966-8764

To schedule a procedure please complete this detailed referral form and return it to us via fax at (919) 966-8764. The patient will be contacted and an appointment scheduled after the referral has been received.

- ☐ Anorectal Manometry (includes Anorectal manometry CPT 91122, EMG CPT 51784, Rectal Sensation, Tone, & Compliance CPT 91120 & expulsion catheter)
- ☐ Helicobacter Pylori (C-13) Breath Test CPT 83013
- ☐ Hydrogen Breath Test for Small Bowel Bacterial Overgrowth and Methanogen Overgrowth CPT 91065
- ☐ Hydrogen Breath Test for Lactose Intolerance CPT 91065
- ☐ Hydrogen Breath Test for Fructose Intolerance CPT 91065

*****When multiple hydrogen breath tests are ordered, they will be scheduled on separate days.*****

- ☐ Esophageal Manometry CPT 91010
- ☐ Esophageal Manometry w/Esophageal Function Test (EFT) CPT 91010 & 91037
- ☐ pH probe, 24 hour ambulatory CPT 91037: ____off PPI ____on PPI
- ☐ pH/Impedence, 24 hour ambulatory CPT 91038 ____off PPI ____on PPI

Indication(s):

- ☐ Abdominal Pain
- ☐ Asthma/reactive airway
- ☐ Bloating
- ☐ Constipation
- ☐ Chest Pain (non-cardiac)
- ☐ Cough
- ☐ Diarrhea
- ☐ Dyspepsia
- ☐ Dysphagia
- ☐ Failure to respond to treatment
- ☐ Fecal Incontinence
- ☐ GERD
- ☐ Globus
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Proctalgia
- ☐ Regurgitation
- ☐ Shortness of Breath
- ☐ Throat Burning
- ☐ Throat Clearing
- ☐ Other: _____

Co-Morbidities:

- ☐ Anticoagulation Therapy
- ☐ Asthma/reactive airway
- ☐ Bleeding Disorder
- ☐ Communicative Disease
- ☐ CAD/CHF/Cardiac Disease
- ☐ Diabetes
- ☐ Immunosuppressed
- ☐ Neurological Impairment
- ☐ Transplant (organ_____)
- ☐ Other: _____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:		MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:	SEX: F ☐ M ☐	BIRTH DATE:
STREET ADDRESS:			
CITY:	STATE:	ZIP:	
MEDICAL RECORD # (IF KNOWN):			

REFFERING PHYSICIAN INFORMATION

PHYSICIANS NAME:		
PRACTICE NAME:		
STREET ADDRESS:	CITY, STATE, ZIP	
PHONE:	FAX:	EMAIL ADDRESS:

Pediatric patients require admission to the hospital for a pH/impedance or pH test. Please request a bed assignment for the date of the procedure. If the referring is **not** a UNC physician, please call the Pediatric Admitting Coordinator Attending at 919-843-6501 or page 919-123-5437 to request a bed.

Please fill out this form completely and fax to 919-966-8764. All tests require a referral from a medical provider along with an indication for the diagnostic test. **BREATH TEST STUDIES ARE COMPLETED AT 100 EASTOWNE GI OUTPATIENT CLINIC, CHAPEL HILL, IF QUESTIONS REGARDING STUDIES please call 984-974-0140.**

Interoffice use only: Date scheduled: _____ Time: _____