**Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Family Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Date Ordered**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Appointment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YYYY/MM/DD YYYY/MM/DD

**□ 13C UREA BREATH TEST** (for H.pylori)

**□ LACTOSE HYDROGEN BREATH TEST / HYDROGEN BREATH TEST**

**□ FECAL WEIGHT - □** 48 Hour Collection □ 72 Hour Collection

**►□ GLUCOSE HYDROGEN BREATH TEST –** **BACTERIAL OVERGROWTH**

**Test available after assessment; by appropriate Specialist.**

**(Medicine, Surgery, Gastroenterology, Pediatrics)**

Please indicate the underlying precondition:

**□** Small bowel diverticulosis

**□** Post-Surgical structural resection

**□** Ileocecal valve resection

**□** Gastric bypass/Roux-en-Y resection

**□** Hypo- or achlorhydria

**□** Small bowel dysmotility –please specify the cause:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| SIGNATURE (Referring Physician) |  | PRINTED NAME |  | DATE (YYYY/MM/DD) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| REFERRING PHYSICIAN ADDRESS | |  | TELEPHONE # |  | FAX # | |
| ***FAX Referral to the GI Function Testing Unit – Fax #613-544-4137***  ***Please notify patients that they will:***   1. Be contacted by the Hospital with the appointment date and time 2. Need to bring their health card with them. | | | | |