



GREATER LANSING

**ORDER FORM FOR OUTPATIENT  
ESOPHAGEAL TESTING**

Esophageal Manometry

24-hour pH Monitoring

CPT: \_\_\_\_\_ ICD-10 diagnosis

**Clinical Impression/Reason for Study:**

Chronic cough

Reflux (GERD)

Abnormal EGD

Achalasia

Other (Please add Comments)

Dysphagia

Comments: \_\_\_\_\_

Is the Patient on Proton Pump Inhibitor/H2 Blocker/Antacid Therapy:  Yes  No

Study to be performed  ON  OFF Proton Pump Inhibitor / H2 Blocker / Antacid

*(For PH study, recommend Proton Pump Inhibitor off x 7 days; H2 blockers off x 12 hr)*

PATIENT INFORMATION

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Cell/Work: \_\_\_\_\_

REFERRING PHYSICIAN

Referred By: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Thank you for referring your patient to McLaren for Esophageal Testing**

To provide the best and most efficient service, please fax all recent records, Esophagram reports, Upper GI Series, endoscopy, and any results along with this form to:

**MGL Surgery Scheduling: (517) 975-2206**

Also, please include usual MGL procedure scheduling form in addition to this form.

Ordering physician signature: \_\_\_\_\_ Date/time: \_\_\_\_\_

Please always feel free to contact us at  
517-975-3275 with any questions,  
or if we can assist you in any way.



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