Department of Gastroenterology
John Hunter Hospital

Health
Hunter New England
Local Health District

REFERRAL TO BE FAXED TO: 4922 3900

To: **Dr. Alkesh Zala**

I request for the patient listed below to undergo the procedure/s I have specified with a tick:

REFERRING SPECIALIST	**PATIENT DETAILS**
DATE:	Name:
	Address:
DR.	
PH:	PH:
	MRN:
	DOB:
	◯ MALE ◯ FEMALE

PLEASE TICK REQUIRED PROCEDURES

◯ **OESOPHAGEAL MANOMETRY**	**Please advise patient of the following**:
◯ **AMBULATORY pH STUDIES** ◯ On acid suppression **OR** ◯ Off acid suppression	1. Clinic conducts procedures: Thurs & Fri only 2. Located in: Endoscopy Unit – RNC 3. Nil to eat or drink 5 hrs prior to procedure 4. Bring Medicare card to appointment 5. Patient may drive as no sedation is given 6. Take medication prior to procedure on instruction 7. Appointment will take approx. 1 hr. If pH studies are required, patient will need to return the following day to have the study removed. Please allow 5-10 min
◯ **IMPEDANCE STUDIES**	

Clinical Notes: Diagnosis / Indication for Study:

_____

_____

_____

Patient's Medications:

_____

_____

Signature:_____

ENDOSCOPY CONTACT DETAILS:
JOHN HUNTER HOSPITAL – ROYAL NEWCASTLE CENTRE- Level 3, Interventional Suite
Phone: (02) 4922 3618 Fax: (02) 4922 3900 Hours: 0830-1630hrs