



GastroLife Referral Form

Patient Details			
Name		MRN	
Address		Email	
		DOB	
		Phone Number	

Procedure Required (Tick as Required)			
Small Intestinal Bacterial Overgrowth (SIBO)		Helicobacter Pylori (Urea Breath Test)	
Lactose Malabsorption		Helicobacter Pylori (Urea Breath Test) Post Treatment	
Faecal Calprotectin		Helicobacter Pylori Stool Antigen Test	
Faecal Pancreatic Elastase		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					
Halitosis		Diverticular Dx		Positive Response			
Oesophagitis		Barretts		Moderate Response			
Vomiting		Nausea		No Response			

Referrer Details			
Name		Phone	
Address		Fax	
		Email	
Referral Date		Signed	
Consultant			GP

Please forward all postal correspondence to our Kildare address. Alternatively, completed forms can be faxed to (01) 5242593 or emailed to info@gastrolife.ie