

01 Patient details

Please handwritten in BLOCK CAPITALS.

FULL NAME

DATE OF BIRTH

ADDRESS

PHONE NUMBER

EMAIL

EIRCODE

02 Tests required

Tick all tests required.

BREATH TESTS

- ☐ Small Intestinal Bacterial Overgrowth (SIBO)
- ☐ Lactose malabsorption
- ☐ Fructose malabsorption
- ☐ Sorbitol malabsorption
- ☐ Sucrose malabsorption

STOOL TESTS

- ☐ H. pylori stool antigen
- ☐ Faecal calprotectin
- ☐ Faecal pancreatic elastase
- ☐ FIT (bowel cancer screening)
- ☐ Colosafe® Stool DNA

03 Clinical information

SYMPTOMS

- ☐ Bloating
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Altered bowel habit
- ☐ Flatus
- ☐ Fullness
- ☐ Cramps
- ☐ Belching
- ☐ Gastric reflux
- ☐ Fatigue
- ☐ Halitosis
- ☐ Vomiting / Nausea

DIAGNOSES / HISTORY

- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ H. pylori
- ☐ Coeliac disease
- ☐ Pancreatic disease
- ☐ IBS
- ☐ GORD
- ☐ Gastritis
- ☐ Adhesions
- ☐ Bariatric surgery
- ☐ GIT surgery
- ☐ Diverticular disease
- ☐ Barrett's oesophagus

INVESTIGATIONS

OGD ☐ Yes ☐ No

Result

Colonoscopy ☐ Yes ☐ No

Result

DIETARY RESPONSE

☐ Positive ☐ Moderate ☐ None

04 Referrer details

NAME

PHONE

FAX

ADDRESS

EMAIL

REFERRAL DATE

SIGNED

☐ Consultant

☐ GP