

Fax completed form and insurance information to:

Fax: 303-270-2153 | Attn: MIDC Clinic

---

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Diagnosis / Clinical Indication: \_\_\_\_\_

---

**REQUESTED PROCEDURES (Select all that apply)**

**ANORECTAL PHYSIOLOGY**

Anorectal Manometry (CPT 91124, 91125)

Pudendal Nerve Testing (CPT 95907)

---

**ESOPHAGEAL TESTING**

Esophageal Manometry with Impedance (CPT 91010, 91037)

24-Hour pH Impedance Study (CPT 91038) **\*All 24-Hour pH Impedance will require manometry for probe placement**

**On Acid Suppression Medication:**

Yes  No

*\*\*Referring provider is responsible for medication instructions prior to testing.*

---

**HYDROGEN BREATH TESTING (CPT 91065)**

SIBO (Glucose used unless Lactulose is specifically requested)

Fructose

Lactose

Sucrose

---

**REFERRING PROVIDER INFORMATION**

Referring Physician Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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

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

*This form is intended for external referrals only. Incomplete forms may delay scheduling.*

National Jewish Health | Minimally Invasive Diagnostic Center | 1400 Jackson Street | Denver, CO 80206 | Phone: 303-270-2424



ION100:Î  
Referral-Incoming \_CC

Patient ID

**OUTSIDE REFERRAL ORDER FORM FOR MOTILITY DIAGNOSTIC TESTING**

MID 402E (03/26)