Barium Swallow Test Form

Patient Information

Name:

Date of Birth:

Medical Record Number (if applicable):

Address:

Phone Number:

Referring Physician

Name:

Contact Information:

Clinical History

- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Dysphagia (Difficulty swallowing)
- ☐ Hiatal Hernia
- ☐ Esophageal Abnormalities
- ☐ Other (Specify): _____

Allergies:

- ☐ None
- ☐ Barium
- ☐ Other (Specify): _____

Current Medications

List any medications the patient is currently taking

Patient Consent

I, the undersigned, consent to undergo a Barium Swallow Test under the provider's supervision. I understand the procedure's purpose, potential risks, and benefits. I have had the opportunity to ask questions and have received satisfactory answers.

Signature of Patient: _____ Date: _____

Procedure Details

Date of Test:

Time of Test:

Location (Clinic/Hospital):

Procedure Description

The Barium Swallow Test involves ingesting a liquid solution containing barium sulfate to visualize the upper gastrointestinal (GI) tract. X-ray imaging will capture images of the GI tract during the procedure.

Medical Professional's Notes and Observations

☐ The procedure was completed as planned

☐ Any complications or adverse reactions (if applicable)

Results and Interpretation