

Gastric Emptying Test Request and Reporting Form

Patient Information

Name:

Date of Birth:

Gender:

Medical Record Number:

Contact Information

Address:

Phone:

Email:

Referring Physician Information

Name:

Clinic/Hospital:

Contact Information

Address:

Phone:

Email:

Reason for Referral

- Symptoms suggest gastroparesis (nausea, vomiting, abdominal pain, early satiety, etc.)
- Unexplained gastrointestinal symptoms
- Monitoring treatment efficacy
- Preoperative evaluation
- Other (Specify): _____

Test Details

Test Date:

Test Time:

Fasting Period:

- Overnight
- Other (Specify): _____

Radiopharmaceutical Used:

Instructions to the Patient

Please arrive in a fasting state as instructed.

- The patient has been educated about the test.
- Consent obtained.

Test Procedure

- A standard gastric emptying test will be performed involving the ingestion of a meal containing a radioactive tracer.
- Images will be captured at specific intervals (e.g., 1, 2, and 4 hours after ingestion) using a gamma camera.

Results and Interpretation

- A radiologist or gastroenterologist will interpret the results.
- Results will be communicated to the referring physician, and a report will be provided to the patient.

Follow-up Plan

Depending on the results, a follow-up appointment may be scheduled to discuss treatment options and further management.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____