Gastric Emptying Test Report

Patient information	
Name:	
Date of birth:	**Gender:**
Phone number:	**Email address:**
Home address:	
Medical record number:	**Date of test:**
Referring physician or doctor:	
Clinical indications:	**Primary reason for test:**

Pre-test preparation
Fasting duration (hours prior):
Relevant medications withheld:
Blood glucose (if applicable):
Food allergies (e.g., egg, gluten):
Pregnancy status (if applicable):

Type of meal

- ◯ Standard (egg white, toast, jam, water):
- ◯ Modified (gluten-free, pediatric-appropriate, etc.):
- ◯ Other:

Method used	Patient results
◯ Gastric emptying study	◯ Normal gastric emptying
◯ Upper GI series or barium swallow	◯ Delayed gastric emptying
◯ Gastric emptying breath test	◯ Fast gastric emptying
◯ Smart pill	◯ Other:
◯ Other:	

Summary of findings	
Name of interpreting clinician:	
Signature:	**Date of report:**