# 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:** _____