

# Referral (Adult and Paediatric)

Date: .....

## Patient Details:

Patient Name: ..... D.O.B: .....

Ph: ..... Parent/Carer name if child: .....

## Referral for:

- |   |  |
|---|--|
| <input type="checkbox"/> Gut-directed Hypnotherapy            | <input type="checkbox"/> Pelvic Health Physiotherapy |
| <input type="checkbox"/> Gut-Psychology (CBT/other therapies) | <input type="checkbox"/> Dietetics                   |

## Condition/s:

- |  |  |
|--|--|
| <input type="checkbox"/> Irritable Bowel Syndrome (IBS)    | <input type="checkbox"/> Nausea                          |
| <input type="checkbox"/> Functional Gastric/Abdominal Pain | <input type="checkbox"/> Dysphagia & Globus              |
| <input type="checkbox"/> Functional Dyspepsia              | <input type="checkbox"/> Aerophagia & Excessive Belching |
| <input type="checkbox"/> Gastroesophageal Reflux Disorder  | <input type="checkbox"/> Abdominal Migraine              |
| <input type="checkbox"/> Functional Heart Burn             | <input type="checkbox"/> Coeliac Disease                 |
| <input type="checkbox"/> Pelvic Pain                       | <input type="checkbox"/> Encopresis/Faecal Incontinence  |
| <input type="checkbox"/> Rumination                        | <input type="checkbox"/> IBD Counselling                 |
| <input type="checkbox"/> Cyclic Vomiting                   | <input type="checkbox"/> Other, pls specify below        |

## Notes:

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## Referred by:

Name: ..... Phone: .....

Clinic: ..... Email: .....