

ANORECTAL PHYSIOLOGY REQUEST

Colorectal Surgery Services, PLLC

Patients are required to give 3 days' notice for any cancellations

Patient's Name: _____

D.O.B.: _____ SSN: _____ Sex: M F

Requested date: Tuesday _____ Requested Time: _____ am

Procedures Requested:

- Anal Manometry Surface EMG PNTML
 Defecography Rectal Ultrasound Anal Ultrasound

Diagnosis: _____

564.00	Constipation (simple)	787.6	Fecal Incontinence
564.01	Constipation (slow transit)	625.6	Stress Urinary Incontinence female
564.02	Constipation (outlet dysfunction)	788.3	Stress Urinary Incontinence - male
564.09	Constipation (atonic, spastic, other)	569.1	Rectal prolapse
618.04	Rectocele	728.85	Muscle Spasm

Authorization #: _____

Notes: Take two Fleet™ enemas the night before your procedure. Repeat the morning of your procedure if needed.

Signed: _____

Information sent for chart:

- Office History and Physical Last office progress note
 List of referring doctors Reports from preoperative workup

Make sure that the information sent with this request is available to Dr. Winston & on the patient's chart. Please call the office with questions (210) 490 - 2828
