

REFERRAL FOR TESTING

8 Hearts Health & Wellness
5331 SW Macadam Ave, Suite 380
Portland, OR 97239
Office: 503-894-9118
Fax: 503-894-7398
<http://www.8hearts.org>



Referring Physician: _____ Provider Ph: _____

Referring Physician's Signature: _____ Provider Fax: _____

Do you authorize results to be released directly to this Patient? YES NO

ICD-10 Code(s): _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Ph: _____ Email: _____

Testing Requested:
 Lactulose Bacterial Overgrowth (SIBO Breath Test) Heidelberg Test

Service Type Requested:
 In-Office (BREATH TESTING OR HEIDELBERG) At-Home Testing Kit (BREATH TESTING ONLY)

Results: For In-Office Testing, results are immediate and can be made available to the referring provider within 1-2 business days. For At-Home Testing, please allow us 5-7 business days once we receive the kit back in office.
Payment: Due upon check-in for In-Office Testing; please call the office for payment to have your Home Kit shipped.

Additional requests/comments/information regarding patient care:

Confidentiality statement: This fax and the materials contained within it may contain privileged and/or confidential information that is protected against use or disclosure under federal and state law. Use or disclosure of the contents of this fax by an unintended recipient is in some cases illegal. If you have received this fax in error, please so advise the sender by telephone or email as soon as possible and permanently dispose of the fax. Thank you for your cooperation.