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:

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