

# Referral for Testing

8 Hearts Health & Wellness  
5331 S Macadam Ave Ste 380  
Portland, OR 97239  
Office: (503) 894-9118  
Fax: (503) 894-7398



Referring Physician: \_\_\_\_\_ Referring Physician's Signature \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

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

**IN-OFFICE BREATH TESTING ONLY:** Baseline Hydrogen levels > 14ppm can be indicative of improper prep and may produce unreliable samples for the entire test. If baseline Hydrogen is elevated, do you want your patient to continue the test?  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 pH Test

### Service Type Requested:

At-Home Testing Kit (not an option for Heidelberg testing)

In-Office

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 2-3 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.

Preparation: Upon scheduling, you will receive information for recommended test preparation. Be advised that improper preparation may result in unreliable data for your physician.

Additional requests/comments/information regarding patient care:

\_\_\_\_\_

\_\_\_\_\_

<b>*If Paying by credit card, Fill Out Below</b>		
 <b>MasterCard</b> <input type="checkbox"/>	 <b>Visa</b> <input type="checkbox"/>	<b>Other</b> _____ <input type="checkbox"/>
<b>Card Number</b>		<b>Exp Date</b>
<b>Signature</b>		