Breath Test REQUEST FORM

for Dietary Sugar Malabsorption/FODMAPs

STREAM DIAGNOSTICS
H2Methane BREATH TESTING
www.breathtest.com.au
Phone: 1300 837 863 **Fax:** 1800 852 896 ABN: 29 102 270 468

TESTS REQUESTED: (please tick applicable)

- Lactulose ☑ *Lactulose is the control sugar, and must be provided to set the baseline for the other sugars
- Fructose ☐ *for Fructose malabsorption*
- Lactose ☐ *for Lactose intolerance*
- Sorbitol ☐ *for Sorbitol malabsorption*

} **Key FODMAP tests**

- Glucose ☐ *for Small Intestine Bacterial Overgrowth (SIBO)* Patients with Diabetes should not have the Glucose Test
- Sucrose ☐ *for Sucrose intolerance*
- Mannitol ☐ *for Mannitol malabsorption*

***PLEASE NOTE:** Fructose, Sorbitol and Sucrose tests are not suitable for patients with suspected or confirmed Hereditary Fructose Intolerance

To organise tests:

Please contact our Bookings Office for appointments at our **Breath Test Centres** and to order **Home Test Kits.**

Fax this referral to: 1800 852 896

Call us on: 1300 837 863

Providing tests for patients 8 years old and upwards

PATIENT DETAILS *Please print clearly & legibly in capitals - thank you*

SURNAME **FIRST NAME** **Date of Birth** **Sex** F M

ADDRESS

ADDRESS *line 2* **POST CODE**

PHONE: *(mobile preferred)* **EMAIL:** *(only used to provide breath test information)*

MEDICARE NUMBER

Hospital Status: State the patient's status at the time of the service or when the specimen was collected:

- Private patient in a private hospital or approved day hospital facility ☐
- Private patient in a recognised hospital ☐
- Public patient in a recognised hospital ☐
- Outpatient of a recognised hospital ☐

Medicare Assignment: (Section 20A of the *Health Insurance Act 1973*) I offer to sign me right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligibile pathologist determinable service(s) established as necessary by the practitioner.

X *PATIENT* Patient's Signature — Date / / — Practitioner's Use Only — X *DOCTOR* (Reason Patient Cannot Sign)

CLINICAL NOTES

☐ Self Determined

☐ Irritable Bowel Syndrome ☐ Diabetes
☐ Coeliac Disease ☐ Crohn's Disease
☐ Ulcerative Colitis ☐ Chronic Diarrhoea

Your doctor has recommended that you use Stream Diagnostics. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

REQUESTING PRACTITIONER

Referred by: **Provider No:**

Address:

Date of request: _____

Phone: **Fax:**

Signature: X *DOCTOR* _____

PATIENT COPY

SURNAME **FIRST NAME** **Date of Birth** **Sex** F M

ADDRESS

ADDRESS *line 2* **POST CODE** **MEDICARE No**

PRIVACY NOTE: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the *Health Insurance Act 1973.*

Referring Doctor Details:

Tests Requested:

- Lactulose ☑
- Fructose ☐
- Lactose ☐
- Sorbitol ☐
- Glucose ☐
- Sucrose ☐
- Mannitol ☐