Center for SIBO Testing
a subsidiary of Cascade Integrative Medicine
450 NW Gilman Blvd, Ste 201
Issaquah, WA 98027
Phone: (425) 395-7544
Fax: (425) 391-8091

Laboratory Requisition for Hydrogen and Methane Breath Test (SIBO)

Fax completed requisition to: (425) 391-8091

Ordering Physician

TEST KIT ORDERED ☐ SIBO WITH LACTULOSE (*Faxed prescription required*) ☐ SIBO WITH GLUCOSE (*No prescription required*) ☐ SIBO WITHOUT LACTULOSE (FOR PATIENTS OUTSIDE OF WA) *Provider must supply patient with prescription for lactulose 10g/15mL to obtain from local pharmacy*
ORDERING PHYSICIAN
CLINIC NAME
CLINIC STREET ADDRESS
CLINIC CITY, STATE, ZIP

PHYSICIAN SIGNATURE	ORDER DATE

ICD-10 Codes

☐ R10.0 ☐ R10.1 ☐ R10.11 ☐ R10.12
☐ R10.13 ☐ R14.0. ☐ R14.1. ☐ R14.2
☐ R14.3 ☐ R19.7 Other_____

_____

Patient Demographics

LAST NAME	FIRST NAME	M.I.

SEX ☐ Male ☐ Female ☐ Other	DATE OF BIRTH

PATIENT STREET ADDRESS
PATIENT CITY, STATE, ZIP

PATIENT PHONE #	PATIENT EMAIL

Self-Pay? ☐ Yes ☐ No	If yes, please enclose a check for $225.00 payable to Cascade Integrative Medicine. If no, complete insurance information below.

Primary Insurance Information

INSURANCE CARRIER	

MEMBER ID	GROUP ID

PRIOR AUTH #	RELATION TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME

SUBSCRIBER'S SEX ☐ Male ☐ Female ☐ Other	SUBSCRIBER'S DOB

SUBSCRIBER'S ADDRESS

Secondary Insurance Information

INSURANCE CARRIER	

MEMBER ID	GROUP ID

PRIOR AUTH #	RELATION TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME

SUBSCRIBER'S SEX ☐ Male ☐ Female ☐ Other	SUBSCRIBER'S DOB

SUBSCRIBER'S ADDRESS