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+IMO)

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