Gastroenterology Consultants, PC

♦ P (541) 779-8367 ♦ F (541) 779-7471 ♦ 2860 Creekside Circle, Medford OR 97504

Fructose Breath Test Analysis Report

Date: Report Date GCPC Provider: Provider Name Pt Acct #: Code

Patient Name: Patient Name DOB: Date of Birth Age: Age
Primary Insurance: Primary Insurance Plan

Referring PCP: PCP Name

Medical Assistant: Login Name

This test is not paid for by **Pacificsource**, **Providence or MODA Insurance**, patient must speak with the Billing Department.

Diabetic ☐ Yes ☐ No (if yes, see instruction #5)

Patient Symptoms: Diagnosis

Procedure: 25 grams of Fructose

PATIENT TO COMPLETE THE FOLLOWING:

Describe your last meal: _____

_____

Any allergies to antibiotics:_____

Please chart your symptoms when you take a sample (0= none, 4= severe)

Sample	Time		Nausea (0-4)	Bloating (0-4)	Cramps (0-4)	Gas (0-4)	Diarrhea (Y/N)
1.	20 Minutes	Baseline					
2.		20 min.					
3.		40 min.					
4.		60 min.					
5.	30 minutes	90 min.					
6.		120 min.					
7.		150 min.					
8.		180 min.					

FOR OFFICE USE ONLY

H_2	CH_4	CO_2	Corr.

Please return this form with your sample kit immediately after completion. Test must be completed within 30 days of being issued.
Questions, please call our office at 541-779-8367
For an instructional video visit our website www.gcpcmedford.com, found under the 'Info' tab.

BREATH HYDROGEN TEST
PATIENT INSTRUCTIONS

Your provider has ordered a hydrogen breath test for you. This test is easily performed by the patient in the comfort of their home. You will need 3 hours to complete this test. Below are instructions for you to follow. You can also find an instructional video at our website, www.gcpcmedford.com, found under 'Info'.

1. If you are taking antibiotics you will need to be off of them for 10 days prior to taking this test.
2. Follow the dietary instructions on the attached sheet the day prior to doing your test.
3. Take out your test tubes and labels from the kit. Number each label and write your name, date, and time that you are doing the test *(please write legibly, if this is not done correctly we will not be able to process your test results. If you have to repeat the test there will be a second charge)*
4. **You must be fasting (without food or drink) for 12 hours prior to doing your test.** You may have water up to one hour before taking the test. You will not have anything to eat or drink other than your test solution until after the test has been completed
5. **Diabetic instructions:** If you take oral medication, hold the morning dose the day of the test. If you take Insulin, take ½ of your usual dose the morning of the test. You must monitor your blood sugars during the test.
6. Prescription medication must be taken at least an hour prior to starting the test with a small sip of water. Do not take any medication during the test period.
7. Lay the numbered test tubes out in order 1 through 8.
8. Collect your baseline breath sample **(tube #1)**. Hold the easy sampler device in one hand and the test tube in the other. You will only exhale once per each sample collection. Take a normal breath, close your mouth around the mouthpiece then blow out normally. As you exhale, the bag will fill with air, keep it inflated. Insert the test tube into the needle holder completely so the stopper on the tube is punctured. After 2 seconds, remove the tube from the needle holder and stop exhaling. *(There are no "do overs" this must be done correctly for us to process your test results)*
9. Chart your symptoms on the lower left hand corner of the analysis form. *(zero is no symptoms, 4 is the most severe)*
10. Take the **test solution packet** out of the kit and mix the contents of the test solution packet into 1 cup (8 ounces) of warm water.
11. **Set your timer** and start sipping the solution until it is completely gone. You must be done with your drink before the timer goes off and you obtain the next sample in tube #2. *(see the analysis form to see when your next sample is due)*
12. When your timer goes off, follow the instructions in section #8 (*above*) to obtain the next sample in tube #2 *(you must obtain the samples at the time listed on your analysis form).*
13. Set your timer for the next collection time and then collect sample #3. Chart your symptoms after you collect your sample.
14. Follow the instructions in section #8 until you have obtained samples in all of the tubes enclosed.
15. After you complete the test, you are free to eat and drink. We urge you to rehydrate by having a large glass of water.
16. Return the kit to our clinic, 2860 Creekside Circle, Medford, OR 97504, as soon as possible as the air in the test tubes are only good for so long. The kits will be processed in the order in which they are received.

    Office hours: Monday through Thursday, 8:00a-5:00p, closed on Fridays.
17. We will notify you of your test results **within 2 weeks** after we receive your kit back in the clinic.

Dietary Guidelines for Testing
Please read carefully

****<u>The day prior to the test, you must start the following diet:</u>**

Baked or broiled chicken, fish, or turkey (salt and pepper only).
Plain steamed white rice.
Eggs.
Clear chicken or beef broth.
Plain water, black or green tea (no herbal), or black coffee (no dairy, creamer, or sweeteners).

****Please DO NOT consume any food or drink items if is not on the above list****

****<u>Day of the test, (3 hour test)</u>:**

- You may have **<u>nothing by mouth</u>** for 12 hours prior to the test. Only water may be consumed.
- Take any required medication 1 hour before test with a small sip of water.
- No water within an hour of starting test.
- No smoking, including second-hand smoke, 1 hour before or at any time during the test.
- No sleeping or vigorous exercise, 1 hour before or at any time during the test.
- Perform the test (see the instructions that are attached). Make sure that you label and number each test tube correctly or your test results will be inconclusive.
- Return the kit with your analysis report as soon as possible.

* You will be notified of your results within 14 days after we receive your completed kit.
* If test is not completed or is done incorrectly you will be charged for test.
* If you have any questions either before you start the test or during the test, please call our office at 541-779-8367.
* You can also find an instructional video at our website, **<u>www.gcpcmedford.com</u>**, found under 'Info'.

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MA's Please put in Karyl's Inbox

Patient name: Patient Name Date: Report Date
DOB: Date of Birth

Breath Test Billing information.

The CPT code is: 91065

The Diagnosis code is: Diagnosis

☒	Fructose Test	$28.00	kit only
☐	Lactose Test	$32.00	kit only
☐	Lactulose Test	$40.00	kit only
☐	Glucose Test	$33.00	kit only

Insurance: Primary Insurance Plan
MODA, Pacificsource and Providence do not cover.

☐ Patient has met with Billing to pay $200
Provider: Provider Name

☐ Postage to patient $3.80