REMEDIES
PHARMACIES & CLINICS

H2 / CH4 Breath Test Referral

Name:_____ ID:_____

Contact number: _____ E-mail:_____

Indication: *Choose the test that is required*

1. Test for Small intestinal Bacterial Overgrowth
2. Test for Lactose Intolerance

Current treatment:_____

Any antibiotics within the last 4 weeks: Y / N

Is the patient on pre-/probiotics : Y / N

Referring doctor:_____ E-mail address: _____