Ho'o Lokahi
Lokahi Health Center
www.lokahihealth.com

SIBO Lactulose Breath Test Requisition Form

Provider Information
Clinic Name: _____
Clinic Address: _____
Phone: _____ Fax: _____ E-mail: _____
Provider Name: _____ Credentials/Degree Designation: _____
License Number: _____ NPI: _____

Patient Information
Patient Name: _____ DOB (month/day/year): _____
Patient Mailing Address: _____
Phone Number: _____ E-mail: _____

Shipping Information
Ship to: ☐ Patient Address ☐ Clinic/Provider Address

Billing Information
☐ Patient Pay ☐ Provider Pay ☐ Contact Patient for Payment
Name of Person Responsible for Charges: _____
Credit Card Number: _____
Expiration Date: _____ Security Code: _____
Total Charge Amount: $180.00 + tax Payer Signature: _____
* Payment is processed before test-kit is shipped. Results are guaranteed 7 days after receiving returned test kit.

Results Reporting
E-mail Results To: _____ Fax Results To: _____

By signing below, the requesting provider is attesting to the truthfulness of the statements and information provided above. Lactulose is a FDA controlled legend drug requiring a prescription from a licensed healthcare provider with prescribing authority. By signing below, you certify a valid prescription of the lactulose included in the testing kit for your patient.

Provider Signature: _____ Date: _____

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