GASTRO HEALTH

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FRUCTOSE BREATH TEST PREPARATION

You are scheduled for a Fructose Breath Test on:_____ at: _____ in Suite 110

****A $50.00 cancellation fee will be billed directly to the patient for any appointment not cancelled with a 48 hour notice.****

Your doctor believes you might be having difficulty digesting and absorbing fruit sugar fructose. There is a simple and painless test which can be done to help determine how well you absorb sugar. It requires that some of the breath you breathe out be collected after you drink a solution of fruit sugar and water. The breath will be analyzed for the presence of hydrogen, which is not usually found unless you cannot absorb the sugar which you have drunk.

PREPARATION for the test:

1. If tolerated, stop medications such as: Miralax, Dulcolax, Docusate, Amitiza, Linzess, Milk of Magnesia, Stool Softners, Digestive Enzymes, Lactase, Metoclopramide, Domperidone **AND ALL OTHER LAXATIVES AND PROMOTILITY MEDICATION** 1 week prior to the test. Please call the office if you have questions.

2. No high-fiber or slowly digesting foods the day before the test. For example: bran, coarse breads, nuts, seeds, beans, fruits, dairy products or vegetables.

3. Liquids only for dinner the night before the test (4hours before fasting time starts). Allowed liquids are chicken broth, beef broth and water.

4. No food, liquids, medication, gum, breath mints and hard candy for at least 12 hours before the test. You may only have sips of water to drink.

5. On the day of the test you may brush your teeth making sure you do not swallow toothpaste. Please do not use mouth wash.

6. No smoking at least 1/2 hour before the test.

7. No sleeping or vigorous exercising for at least one hour before, or during the test.

8. No antibiotics or probiotics such as Align, Florastor and etc. for 4 weeks prior to the test. Notify (or remind) the Doctor or Nurse Practitioner of any recent antibiotic treatment and/or runny diarrhea.

When you come in for the test, you will be asked to drink a sugar-water solution. Samples will then be taken of your exhaled breath at intervals. As comparison, a breath sample will be taken before you drink the solution. The procedure is simple and painless; it involves no needles. The entire test requires several samples taken over a period of 3 hours. During this time, you may engage in quiet activity while waiting between samples. No food or liquids may be eaten during the test.

Gastro Health

ADVANCE BENEFICIARY NOTICE

NOTE: You need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the services that are described below. The fact that your insurance may not pay for a particular service does not mean that you should not receive it. There may be a good reason for your doctor recommending it.

Services:

- **_____ Small Bowel Capsule Endoscopy – Code 91110 - $2500.00**
- **_____ SIBO/Glucose Breath Test/KBT – Code 91065 - $300.00**
- **_____ Lactose Breath Test – Code 91065 - $300.00**
- **___X__ Fructose Breath Test – Code 91065 - $300.00**
- **_____ Urea Breath Test – H.Pylori – Code 78267 - $150.00 – acquisition**
  - **Code 78268 - $300.00 – analysis**
  - **Total $450.00**
- **_____ Fibroscan – Code 91200 - $150.00**

Diagnosis:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself.

You may wish to contact your insurance company directly and give them the information as outlined above regarding the service. The description of the service, the procedure code which will be billed, as well as the fee that would be charged may be given to them for prior approval.

The office will submit the claim to your health insurance. You will, however, be fully and personally responsible for payment of this service if the insurance company denies payment. **No appointment will be made without this signed authorization.**

I want to receive these services. I agree to pay personally for any services denied by my insurance carrier.

_____ _____

Date **Signature of Patient**