

PRESCRIPTION FOR HYDROGEN BREATH TEST

1. Physician to check off test(s) required to be done. Multiple tests will need to be done on separate days, so please note the sequential order of tests required.
 - Lactose Intolerance Test
 - Fructose Intolerance Test
 - Sucrose Intolerance Test
 - Sorbitol Intolerance Test
 - Bacterial Overgrowth Test
 - Intestinal Transit Time

2. Patients are instructed to call the Testing Facility **(516)-650-3355** to schedule the above Test(s). The Testing Facility is located at **1205 Franklin Avenue, Garden City, NY 11530 Suite 150.**

3. Patient Preparation
 - You are required to **COMPLETELY FAST FROM FOOD AND LIQUIDS** for **12 hours** prior to the scheduled test. You may consume **ONLY** plain water during this fast. You may also continue to take your medications during the fast.
 - The Day prior to the test eat a **LOW CARBOHYDRATE DIET (see below)**. This is to avoid foods that produce gas in the intestinal tract which could lead to an inaccurate result on your breath test.
 - If you are a **DIABETIC** you need to speak to your medical doctor about what to do with your diabetic medications during the fast.
 - No** Antibiotics for 4 weeks prior to the Test.
 - No** Exercise the Morning of the Test.
 - No** Smoking the Day of the Test.
 - No** Gum chewing the Day of the Test.
 - No** Mouthwash the Day of the Test.

4. Day of The Test
 - You are required to be at the Testing Family **PROMPTLY** at the scheduled time.
 - You are required to bring this prescription paper the day of the test.**
 - The breath test will consist of you drinking one glass of a specific carbohydrate liquid that the Testing Facility will supply to you. After which, you will be required to breathe into a small tube every 30 minutes. The length of the test could be up to a total of 3 hours. You may bring reading material with you to keep you occupied.

Cancellation Policy

- ✓ If you must cancel your procedure, please notify our office **within 24 hours** prior to your procedure. Failure to do so will result in a **\$50.00** charge to your account.

DIET RECOMMENDATIONS FOR DAY PRIOR TO TESTING

	Allowed	Avoid
Grains/starches	Rice, quinoa, potato, oatmeal, corn tortillas, popcorn, gluten free bread/crackers/pasta/cereal	Wheat products, rye, barley
Vegetables	Bell peppers, carrots, cucumber, eggplant, green beans, kale, lettuce, olives, spinach, squash, zucchini, tomato	Artichoke, asparagus, cauliflower, garlic, leeks, mushrooms, okra, onion/shallots, snow peas, sugar snap peas
Fruit	Banana, blueberry, cantaloupe, cranberry, grapes, honeydew, kiwi, lemon, lime, orange, papaya, pineapple, pomegranate, raspberry, strawberry	Apple, apricot, blackberry, cherry, dried fruit (raisins), grapefruit, mango, nectarine, pear, peach, plum, prunes, watermelon
Proteins	Meat, eggs, fish, tofu, most nuts (see “avoid” column), peanut butter, almond butter	Beans, hummus, edamame, cashews, pistachios
Dairy	<i>Lactose-free</i> milk/yogurt/ice cream, rice milk; any aged or hard cheese (including cheddar, provolone, swiss, parmesan, feta, goat, etc)	Milk, yogurt, ice cream, cottage cheese, ricotta cheese, soy milk, almond milk
Beverages	Water, coffee, tea, sugar-free beverages (crystal light, diet pop)	Regular soda and other beverages with high-fructose corn syrup
Sweeteners	Pure maple syrup, sugar substitutes (such as Stevia), table sugar	Agave, honey, high fructose corn syrup