Patient Name: _____ □ **JAMES D. TOROSIS, M.D.**

Patient DOB: _____/_____/_____ □ **VICKY W. YANG, M.D.**

Test Date: _____/_____/_____ □ **DANIEL S. RENGSTORFF, M.D.**

Location: 2900 Whipple Ave Ste 245 Redwood City, CA 94062 □ **CYNTHIA W. LEUNG, M.D.**

Breath Test Preparation Instructions - SIBO | LACTOSE

4 WEEKS BEFORE THE PROCEDURE
Stop taking any antibiotics.

1 WEEK BEFORE THE PROCEDURE
Do not have a colonoscopy or barium enema. Do not take any laxatives, probiotics, stool softeners, or bulking agents (for example Colace, milk of magnesia, Ex-Lax, Metamucil, or Citrucel)

1 DAY BEFORE THE PROCEDURE
You may ONLY consume foods from the following list - ABSOLUTELY NO SUBSTITUTIONS!

- Plain white bread
- Plain white rice
- Plain white potatoes
- Baked/broiled chicken or fish
- Water
- Black coffee or tea
- Salt

After 9:00 PM, you may only drink water. Do not consume any solid food.

THE MORNING OF THE PROCEDURE
Wake up at least 1 hour before your test begins. Do not exercise vigorously prior to your test.

During the test, *do not sleep or exercise. Do not smoke, chew gum, or eat anything.*

You will be at the office from **8:30 AM – 11:30 AM** while the test is run. You may bring a water bottle and any work or activity to pass the time. Please call our office at (650) 365-3700 if you have any other questions.

Breath Test Cancellation Policy

Due to the limited availability of appointments for breath tests, we require at least 3 full business days' notice for cancellation or rescheduling. ***It is our policy to charge a late schedule adjustment fee of $75 for breath tests.*** If you do not follow the diet to prep for the test, the test will need to be rescheduled and the fee will be levied. We can waive this fee with a signed doctor's note or if we are able to fill your appointment slot; however, there is no guarantee that we will be able to fill the slot on short notice. The charge for a late cancellation/no-show will be billed directly to you and not to your insurance. Please help us serve you better by keeping your scheduled appointments.

I have read and understand the Breath Test Cancellation Policy in full.

_____
Printed Name of Patient

_____ _____
Signature of Patient, Parent, Guardian or Legal Representative Date