JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

DIVISION OF DIGESTIVE DISEASES
4940 Eastern Avenue
Baltimore, MD 21224-2780
Phone (410) 550-0796 Fax (410) 550-7861

Patient ID

BREATH HYDROGEN TESTING REFERRAL / REPORT

Referring Physician please fill in all **information fields

**Referral Date ________________________ Appointment Date ________________
**Patient Name ____________________ **D.O.B. __________ **Patient Phone number ________
**Referring Provider (print name) ____________________ **Signature ____________________
**Referring Physician Phone Number ____________________
**Clinical History: Antibiotics Yes_____ No_____ Type ________________
Salicylates Yes___ No___ Laxatives/Enemas Yes___ No___ Smoking Yes___ No___ Chronic Diarrhea Yes___ No____
**Patient Weight in Kg. __________Additional Information: ____________________

**Substrate: Lactose Fructose Dextros Lactulose **Dose=_____ kg. X 2 gram / kg =__________ grams (to maximum of 50 gms)

Administered by: (Print) ________________ (Signature) ________________ Date: ____________

METHOD OF COLLECTION: (Circle One) Mask Mouthpiece DIET INSTRUCTIONS GIVEN? [ ] YES [ ] NO [ ] NA

SAMPLE	Time Scheduled	Actual Time	PPM	NOTES
Baseline				
30 minutes				
60 minutes				
90 minutes				
120 minutes				
150 minutes				
180 minutes				
210 minutes				
240 minutes				

INTERPRETATION:

RECOMMENDATION:

MD SIGNATURE/DATE ____________________ MD PRINTED NAME ____________________