Patient Name: _____

DOB: _____

If the patient answers ***YES*** to any of these questions below, the test is ***NOT to be done*** – CONTACT THE LABORATORY.

- Have you consumed any food or drink in the last 4-6 hrs? **Y / N**
- Have you been on the following medications?

  a) Antibiotics in the last 4 weeks **Y / N**

  b) Proton pump inhibitors in the last 7 days **Y / N**

  c) Antacids and H_2 Receptor antagonists during the fasting period **Y / N**

- Are you allergic to maize (corn) starch? **Y / N**

The breath test contains a small amount of radiation - it is less than an average person receives from the natural environment (or background) radiation in a day.

Patient signature:_____**Date**:_____