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***Helicobacter pylori* Breath Test Request Form**

Patient _____ Sex _____ Date of Test _____

ICD-9-CM Code _____ *This MUST be provided by physician*

Date of Birth _____ Soc. Sec. # _____

Address _____ City, State, Zip _____

Phone (Home) _____ Phone (Work) _____

Insurance Co. _____ Address _____

Subscriber _____ Relation _____

Policy # _____ Group # _____

Subscriber Signature _____ *(signature authorization MUST be signed)*

Please include a copy of both sides of insurance card, if possible.

Physician _____ UPIN # _____

Address _____

City, State, Zip _____

Phone _____ FAX _____

Physician Signature _____

Contact Person _____

Time Capsule Taken _____

Time Balloon Blown up _____

Confounding Factors (Check any that apply):

Antibiotics
(last 30 days)

Proton-pump inhibitors
(last 14 days)

Nonfasting
(6 hrs before test)

Bismuth
(last 30 days)

Sucralfate
(last 14 days)

Technically
Suboptimal

Insufficient sample

Sample time missing / incorrect

NONE