Natural Medicine of Stillwater

105 New England Place, Ste. 220
Stillwater, MN 55082
A SocialVite, INC. Company

Referral Form
Please fax this form to 866-462-6742

Referring Provider's Name _____ Phone _____

Clinic Name _____ Fax _____

Address _____ Suite _____

City _____ State _____ Zip _____

Provider's Signature _____ Date _____

Breath Test Kit Requested

☐ Small Intestinal Overgrowth (SIBO) - Lactulose Breath Test*

☐ Small Intestinal Overgrowth (SIBO) - Glucose Breath Test*

Patient Information

Name _____ Date of Birth _____

Mailing Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ Mobile _____

Email (required for receipt) _____

Credit Card (Check one) **Visa** _____ **MasterCard** _____ **AMEX** _____ **Discover** _____

Credit Card Number _____ Expiration _____ Security Code _____

Billing Address

Address _____

City _____ State _____ Zip _____

Name as it appears on the credit card _____

Payment is processed before test collection kits are mailed out. Receipts are emailed, be sure to include your email address.

***Please also submit a patient release of records form so test results can be released to referring practitioner.**