



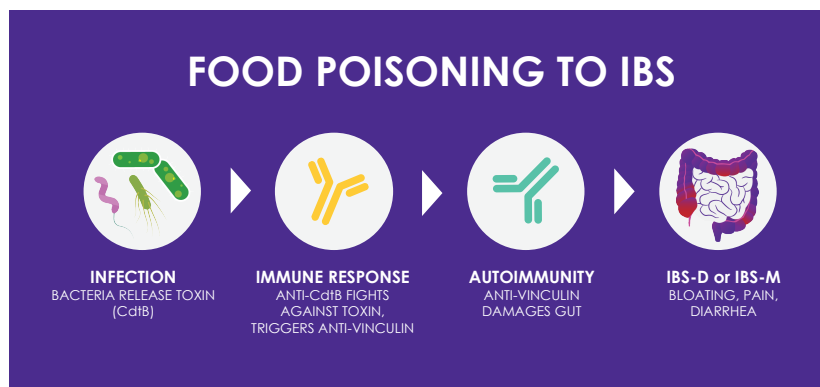
www.ibssmart.com

hello@ibssmart.com

Why could this test be important to you?

ibs-smart™ is a **blood test** that detects **validated IBS biomarkers**, anti-CdtB and anti-vinculin. Elevated levels of either antibody in your blood indicate with high certainty that **you have Irritable Bowel Syndrome**.

In addition, these antibodies indicate that IBS was **caused by an instance food poisoning** at some point in your past. **You may not remember** this episode, but research shows that these antibodies are formed through the following pathophysiological process:



1 in 9 people who experience food poisoning develop IBS.

Klem F, et al. Gastroenterology 2017.
PMID: 28069350

Up to 60% of IBS-D cases could be post-infectious.

Pimentel M. et al. PLoS ONE 2015.
PMID: 25970536

Which symptoms of IBS do you have?

☐ Abdominal Pain ☐ Persistent Gas ☐ Bloating ☐ Urgency

☐ Cramping ☐ Diarrhea ☐ Constipation

ibs-smart™ is applicable to **patients with diarrheal symptoms** (IBS-D and IBS-M). It is not applicable to patients who are constipation-predominant (IBS-C).

IBS can coexist with other illnesses. Please tell you doctor about **any other symptoms**, including blood in your stool and unintentional weight loss.

Your doctor can order the test for you by visiting:

www.ibssmart.com/order

ibsmart™

Blood Test Requisition Form

PacificDx
Laboratory Director: Shelly Gunn, MD, PhD
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ACCOUNT#: _____ **REQUIRED**

PATIENT INFORMATION

Name: _____
FIRST MI LAST
 Date of Birth: ____/____/____
mm dd yyyy
 Sex: ☐ M ☐ F ☐ Decline to Answer
 Email: _____

Address 1: _____
 Address 2: _____
 City: _____ State: _____ Zip: _____
 Phone: _____

PATIENT'S INSURANCE INFORMATION

Check one:
☒ **HMO, PPO, Commercial Insurance**
IMPORTANT: *Please provide front & back copy of insurance card*
 Patient Relationship to Policyholder:

☐ Self ☐ Other: _____

If "other", complete policyholder's information:

Name: _____
 Date of Birth: ____/____/____ Sex: ☐ M ☐ F

☐ **Medicare / Medicaid** - provide front & back copy of ins. card

Subscriber ID: _____

Authorization #: _____

☐ **Self-Pay** - Patient will be billed directly via mail

I authorize any physician or lab who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Pacific Diagnostics. I understand I am responsible for any co-pay or deductible amounts. I understand I am fully responsible for payment of my account if Pacific Diagnostics is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Provider: _____ Policy #: _____

PATIENT SIGNATURE (REQUIRED)



SIGNATURE REQUIRED

DATE _____

ORDERING PRESCRIBER INFORMATION

Prescriber: _____
 Office: _____
 Address 1: _____
 Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____

Select one method for final report delivery.

☐ Email

☐ Fax

Email/Fax: _____

By the referring prescriber named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, and, if required by my institution, has given informed consent.

PRESCRIBER SIGNATURE (REQUIRED)



SIGNATURE REQUIRED

DATE _____

ICD-10 DIAGNOSIS CODE (Required)

☒ K58.0 ☐ K58.2 ☐ K58.9 ☐ K52.9

Other: _____

LABORATORY TEST ORDERED

☒ **ibsmart™** - CPT codes 83520 Anti-CdtB;
 83520 Anti-vinculin

SAMPLE COLLECTION INFORMATION

☐ **Whole Blood, EDTA (Lavendar Top), >2mL**

All other specimens will be rejected. No pour-offs accepted.

Collection Date: ____/____/____ Time: ____:____
mm dd yyyy 24-hr (HH:mm)

Requisition completed by: _____

RECEIVING LAB USE ONLY

Received Date/Time/Tech: _____

[Accession Label]

ibsmart™

For questions, contact clientsupport@ibssmart.com
 The ibs-smart™ test is conducted at PacificDx Laboratories
 Mason, Suite 100, Irvine, CA 92618