

**Sucrose
Intolerance**

It's more common
than you think
www.SucroseIntolerance.com

**Here's information for you to share
with your doctor, including
a **FREE breath test** order form**



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SUC19.3006

FOR YOU

do i have csid?

Take this discussion guide to your doctor so you can review your symptoms and ask the right questions. **Ask your doctor to order the new breath test that can help diagnose CSID.***

1. Have you been diagnosed with any of the following disorders or diseases, but you didn't feel better after treatment?

- Lactose Intolerance
- Irritable Bowel Syndrome (IBS)
- Celiac Disease
- Small Intestinal Bacterial Overgrowth (SIBO)
- Pancreatic Insufficiency (also called EPI)
- Crohn's Disease, Ulcerative Colitis, or Inflammatory Bowel Disease (IBD)
- Viral or Bacterial Gastroenteritis
- Parasitic or Infectious Diarrhea
- Milk Protein Intolerance
- Fructose Malabsorption
- None of the above

2. Have you tried any of the following diets?

- Low-FODMAP
- Lactose-Free (avoid milk, cheese, ice cream)
- Gluten-Free (avoid wheat)
- Other: _____

3. Have you had loose stools or diarrhea more than two times per week for many months or years?

- YES NO

4. Have you had abdominal pain, excessive gas, bloating, or cramping more than two times per week for many months or years?

- YES NO

5. Do you have diarrhea, abdominal pain, excessive gas, bloating, or cramping after you eat?

- YES NO

6. Do you have diarrhea, abdominal pain, excessive gas, bloating, or cramping after you eat sweet or sugary foods such as candy or desserts?

- YES NO

7. Do you have stomach pain after you eat starchy foods, which include corn, potatoes, beans, pasta, rice, and grains?

- YES NO

8. Have you actually lost control of your bowels, meaning have you had an accident because you couldn't make it to the bathroom in time?

- YES NO

9. Are other parts of your life affected? Do you cancel social plans or have you stopped participating in social activities?

- YES NO

10. Do you plan your day around knowing the locations of the nearest bathrooms?

- YES NO

11. Does your doctor know that there is a new breath test designed to aid in the diagnosis of CSID?

- YES NO

12. Is your doctor aware of treatment options for Congenital Sucrase-Isomaltase Deficiency (CSID)?

- YES NO

NOTES:



In addition to following up with your doctor, you can email info@sucroseintolerance.com for more information.

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*This is one of several tests that can be performed to help diagnose CSID. For more information on testing options please visit: sucroseintolerance.com/diagnosis.

FOR YOUR DOCTOR

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Dear Healthcare Provider,

Your patient took a recent online questionnaire indicating signs and symptoms suggestive of **Congenital Sucrase-Isomaltase Deficiency (CSID)**.

CSID, more commonly known as sucrose intolerance, is a relatively rare genetic disease that results in reduced starch and sugar digestion, colonic fermentation, and postprandial (after a meal) nonspecific GI symptoms of **gas, bloating, abdominal pain, and diarrhea**.

The diagnostic workup for CSID is not routine, and most doctors familiar with the disease will rule out more common etiologies, such as IBD, first.

A requisition form for a **FREE sucrose breath test**, which can aid in the diagnosis, is enclosed. The results of the test, along with a thorough patient history, may help inform a diagnosis of CSID. To order the test, complete the form and fax it to **1-617-860-6617**.

The breath test is one of a number of tests that can be performed to help diagnose CSID. For more information on testing options, please visit sucroseintolerance.com/CSIDdiagnosis.



If you have questions, please call **1-888-871-1589** or email info@sucroseintolerance.com.

FOR YOUR DOCTOR

free sucrose breath test

U.S. Only. Only a healthcare provider can order this test. **All information is required.**

Aerodiagnostics LLC™

Phone: 1-617-608-3832

Fax: 1-617-860-6617

customerservice@aerodiagnostics.com

1. Healthcare Provider Information

Clinician information:

Doctor or healthcare provider must fill out this information.

First:

Last:

NPI#:

**IMPORTANT:
ONLY A HEALTHCARE PROVIDER
CAN ORDER THIS TEST**

Office Phone:

Office Fax:

Address:

City:

State:

Zip:

Signature:

Date:

2. Patient Information

Patient information:

Patient must fill out this information

First:

Last:

Date of Birth: Gender (Optional):

Home Phone:

Cell Phone: Work Phone:

Email:

Address:

City: State:

Zip:

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