Stool Gluten Testing

COLLECTION & SHIPPING INSTRUCTIONS

KIT CONTENTS

1 - Requisition Form
1 - Instruction Sheet
1 - Client Questionnaire
2 - Empty Brown Lid Vials
2 - Parafilms
1 - Biohazard bag
1 - Nun's Hat collection container
1 - Cardboard Shipping Box with Ice Pack
1 - UPS Next Day Air Pack (US & Canada only)
1 - UPS Next Day Shipping Label (US & Canada only)

CAREFULLY READ COLLECTION AND SHIPPING INSTRUCTIONS THOROUGHLY BEFORE STARTING.

PLEASE NOTE: When shipping the specimens back to the lab, send Monday through Thursday Only. **DO NOT SHIP ON FRIDAY AS DELIVERIES ARE NOT ACCEPTED ON SATURDAY OR SUNDAY.**

Observed holidays are as follows: New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and the Day After, and Christmas Day.

DO NOT SEND SAMPLE(S) THE DAY PRIOR TO OR THE DAY OF A HOLIDAY.

INTERFERING SUBSTANCES

A few substances will interfere with the analysis of the Stool Gluten Test. Their use needs to be discontinued **ONE-WEEK** prior to collection.

7 DAYS PRIOR TO COLLECTION DISCONTINUE USE OF THE FOLLOWING

- Food products containing the fat substitute Olestra (such as WOW or fat-free Pringles potato chips)
- Medications that block the digestion of dietary fat (like Xenical or other so called "fat blockers")

DIETARY INSTRUCTIONS

Eat the foods and portions you normally eat. You may drink beverages of your choice.

Please call 206.209.4200 with questions or Toll Free 855.405.8378
Monday through Friday 6:00 am – 7:00 pm PST

6839 Fort Dent Way, Ste 206
Tukwila, WA 98188
Fax: 206.209.4211
www.meridianvalleylab.com info@meridianvalleylab.com

COLLECTION INSTRUCTIONS

Before collecting the sample, Place the upper portion of the Styrofoam with the ice pack in the freezer. Do not remove the icepack from the Styrofoam.

1. Lift toilet seat. Place Nun's Hat container with wings on the back of the toilet and lower lid to hold in place. Pass urine into the toilet. **IMPORTANT**: DO NOT LET URINE OR WATER FROM THE TOILET BOWL COME INTO CONTACT WITH THE STOOL SPECIMEN. Alternatively, any clean, plastic container may be used to collect the stool specimen.
2. Pass **ONE COMPLETE STOOL** into the container. Remove the Nun's Hat and replace the lid.
3. Remove the lids from the vials. Place the stool into the vials with the plastic scoop that is attached to the lid. Fill each container completely taking care not to over fill.
4. Replace the lids for each container, please **securely tighten** the lids.
5. Stretch Parafilm around and over cap. **DO NOT PLACE PARAFILM UNDER CAP.**
6. If you do not have enough stool from one collection, save the completed vial in the freezer. Fill the other vial with the next bowel movement.
7. Write name and date on the containers with a permanent marker or ballpoint pen.
8. Place stool containers in the biohazard bag. Seal bag.
9. **FREEZE SPECIMENS** until you can ship them.
10. Complete the enclosed requisition and client questionnaire; include payment (if required).

SHIPPING INSTRUCTIONS

1. Place the requisition in the outside pocket of the biohazard bag.
2. Put the biohazard bag into the shipping box.
3. Replace the Styrofoam lid in the shipping box. Secure the tabs of the shipping box.
4. Place the shipping box in the UPS next day air pack and seal securely.
5. Place return shipping label with barcode on outside of UPS next day air bag.
6. **Save return receipt with the tracking number for your records**.
7. Call UPS toll free at **1-800-742-5877** for a pickup or for nearest drop location. UPS will pick up only on weekdays.
8. When calling for UPS pickup, request **"ON CALL AIR"** only. Do NOT request a one-time pickup. Meridian Valley pays for "**ON CALL AIR**" only. UPS expects the patient to pay for a one-time pickup.

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Meridian Valley LAB

Client Questionnaire – please answer these questions and return with your sample.
This will aid in the interpretation of your tests and understanding of your results.

Name: _____ Date: _____

Phone Number: (_____)_____ Date of Birth _____ Age: _____

Sex: M___ F___ Height: _____ Weight: _____ Blood-Type (if known): _____

Ethnic Origin: Caucasian____ Africa-American____ Asian American____
Native American____ Mexican-American____ Asian-Indian American____ Other_____

1.	Have you lost more than 10 lbs in the last six months?	Yes	No
2.	Have you gained more than 10 lbs in the last six months?	Yes	No
3.	Do you get spells of severs exhaustion or fatigue?	Yes	No
4.	Do you get mouth ulcers?	Yes	No
5.	Do you have frequent abdominal pain?	Yes	No
6.	Do you suffer from frequent indigestion?	Yes	No
7.	Do you vomit often?	Yes	No
8.	Do you often feel bloated after eating?	Yes	No
9.	Do you have frequent loose bowel movements?	Yes	No
10.	Do you have frequent constipation?	Yes	No
11.	Do you have or does alcoholism run in your family? (please indicate whom)	Yes	No
12.	Do you have microscopic colitis (or collagenous or lymphocytic colitis)?	Yes	No
13.	Do you have arthritis, asthma, diabetes, thyroid problems, psoriasis, or any other autoimmune syndrome? If so, list below	Yes	No
14.	Have you been diagnosed with gluten sensitivity or celiac sprue? If so, how?	Yes	No
15.	Has anyone in your immediate family been diagnosed with gluten sensitivity or celiac sprue? If so, how (with what test)?	Yes	No
16.	Are you currently on a gluten-free diet? Is so, for how long?	Yes	No
17.	Did your health improve after going on a gluten free diet? (if applicable)	Yes	No
18.	Did you eat gluten in anticipation of this test? If so, how long?	Yes	No
19.	Have you ever been tested with blood tests for celiac sprue? Is so, what were the results (mention test and results please)	Yes	No
20.	Have you ever has a small intestinal biopsy for celiac sprue? Is so, what did the biopsy show?	Yes	No

What is your main symptom or reason for desiring testing?_____

If your health improved on a gluten free desired, what improved?_____

What medical conditions do you have? _____

What diseases run in your family? _____

On a scale of 1-10, how would you rate your overall health (10 = excellent)? _____

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