

D-Xylose Test Protocol

Patient Information

Name:

Date of Birth:

Medical Record Number:

Date of Test:

Ordered by:

Reason for Test:

Patient Preparation

Fasting Period:

Medication Review:

Test Procedure

- 1. D-Xylose Solution:**
- 2. Urine Collection:**
- 3. Patient Instructions:**

Urine Storage

Laboratory Processing

Interpretation of Results

Follow-up