

**DIRECT ACCESS ENDOSCOPY REQUEST FORM
(GENERAL PRACTITIONER / HEALTH ENRICHMENT CENTRE)**

To make an appointment, please fax this form to:

Fax no: 6357 3765 Telephone no: 9720 8601 / 6357 3766 / 6357 3767 (for main TTSH) **OR**
Fax no: 6556 1479 Telephone no: 6554 6868 (for **AMK Specialist Centre (AMKSC) Day Surgery**)

Patient's Particulars

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| Name: _____ NRIC/ID No.: _____ Address: _____ _____ Contact No.: _____ | Clinic Stamp |
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Indication(s) for Gastroscopy (please tick)

- Recurrent upper abdominal pain / bloating
- Reflux / heartburn

Checklist (please tick)

- For OGD procedure, patient must be able to open the mouth by 3cm gap between the upper and lower incisor to insert the endoscope

Patients with these conditions are *NOT suitable* for Open Access Gastroscopy

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| <ul style="list-style-type: none"> • Physically unfit • Uncontrolled hypertension (BP >180/100) • Diabetic on Insulin • Severe Ischaemic Heart Disease/With Cardiac devices e.g. Cardiac Pacemakers and Stents / Heart Valve Replacement • Severe Pulmonary Disease • Below 21 years • Above 60 years old • Pregnancy | <ul style="list-style-type: none"> • **Haemetemesis or melaena • **Ongoing fresh PR bleeding • On warfarin and NOAC Medications (e.g. Dabigatran, Rivaroxaban, Apixaban, Edoxaban) • Not competent to give consent • Significant loss of weight • AMI / CVA within 6 months • Difficult airway (e.g. short chin, OSA, morbid obesity) <p>** Consider referring to Emergency Department</p> |
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Relevant History (please tick & fill in Drug Allergy section)

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| <p>Medical History: <input type="checkbox"/> Nil <i>(please indicate "Nil" if absent)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes Mellitus (not on Insulin) <input type="checkbox"/> Hypertension <input type="checkbox"/> Ischaemic Heart Disease <input type="checkbox"/> Cerebrovascular disease <input type="checkbox"/> Infectious Diseases (e.g. Hep B/C, HIV) <input type="checkbox"/> Others _____ _____ _____ _____ | <p>Drug Allergy: _____ <input type="checkbox"/> Nil <i>(please indicate "Nil" if absent)</i></p> <p>*Anti-platelet agents <input type="checkbox"/> Nil <i>(please indicate "Nil" if absent)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Aspirin <input type="checkbox"/> Clopidogrel (Plavix) <input type="checkbox"/> Dipyridamole (Persantin) <input type="checkbox"/> Ticlopidine (Ticlid) <p>* No need to stop anti-platelet agents for <u>OGD</u></p> |
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**Please follow up with patients for abnormal Helicobacter Pylori findings.
Patients with biopsy done will be given a follow-up appointment at the respective TTSH clinic
that performed the scope for subsequent care management.**

Name and Signature of Referring Physician: _____

Date / Time: _____

