Tan Tock Seng HOSPITAL

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

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 Centre**) to make an appointment

Patient's Particulars

Name : _____ NRIC/ID no : _____ Address : _____ _____ _____ Contact no. : _____	Clinic Stamp

Indication(s) for Gastroscopy (please tick ☑)	**Indication(s) for Colonoscopy (please tick ☑)**
☐ Recurrent upper abdominal pain / bloating ☐ Nausea / vomiting ☐ Reflux / heartburn ☐ Iron deficiency Anaemia, Hb:_____g/dl ☐ Others _____	☐ Change in bowel habits ☐ Chronic constipation / diarrhoea ☐ Mild PR bleeding / Positive FOBT ☐ Iron deficiency anaemia, Hb:_____g/dl ☐ Others _____

Patients with these conditions are *NOT suitable* for open access endoscopy

• Physically unfit • Uncontrolled hypertension (BP >180/100) • Diabetic on Insulin • Severe Ischaemic Heart Disease/With Cardiac devices • Severe Pulmonary Disease • >75 yrs of age with ≥2 cardiovascular risk factors (DM, hypt, hyperlipidemia, obesity & smoking)	• ******Haemetemesis or melaena • ******Ongoing fresh PR bleeding • On warfarin • Not competent to give consent ***** Consider referring to Emergency Department***

Relevant History (please tick ☑ & fill in Drug Allergy section)

Past Medical History: ☐ Nil
(please indicate "Nil" if absent)
☐ Diabetes Mellitus (not on Insulin)
☐ Hypertension
☐ Ischaemic Heart Disease
☐ Cerebrovascular disease
☐ Infectious Diseases (eg Hep B/C, HIV)
☐ Others _____
_____
_____

☐ Nil
Drug Allergy: _____
(please indicate "Nil" if absent)

***Anti-platelet agents** ☐ Nil
(please indicate "Nil" if absent)
☐ Aspirin
☐ Ticlid
☐ Plavix
☐ Persantin (Dipyridamole)

***Please stop all anti-platelet agents (except Aspirin) 1 week before Colonoscopy or double procedures. Temporary increased in risk of thromboembolic phenomenon has been explained* ☐ Yes

No need to stop anti-platelet agents for OGD alone

Referring Physician: _____ Date: _____
(please print name)