Tan Tock Seng HOSPITAL

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

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

Indication(s) for Gastroscopy (please tick ☑)	**Checklist (please tick ☑)**
☐ Recurrent upper abdominal pain / bloating ☐ Reflux / heartburn	☐ 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

• 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	• ******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) ***** Consider referring to Emergency Department***

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

Medical History: ☐ Nil *(please indicate "Nil" if absent)* ☐ Diabetes Mellitus (not on Insulin) ☐ Hypertension ☐ Ischaemic Heart Disease ☐ Cerebrovascular disease ☐ Infectious Diseases (e.g. Hep B/C, HIV) ☐ Others _____ _____ _____ _____	**Drug Allergy:** _____ ☐ Nil *(please indicate "Nil" if absent)* ***Anti-platelet agents** ☐ Nil *(please indicate "Nil" if absent)* ☐ Aspirin ☐ Clopidogrel (Plavix) ☐ Dipyridamole (Persantin) ☐ Ticlopidine (Ticlid) **** No need to stop anti-platelet agents for OGD***

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: _____