

INSTITUTION REFERRED TO			
Please tick ☐ based on referral type (private / subsidised) and email / fax this form to make an appointment. For subsidised referrals, please include the CHAS referral form.	<div style="display: flex; align-items: center;"> ☐ Pte </div> <p>[OGD] AMK Specialist Centre (AMKSC) Tel: 6554 6868 Fax: 6556 1479 ttsh.amksc.dsc@nhghealth.com.sg</p> <p>[Colono] Tan Tock Seng Hospital (TTSH) Tel: 6357 1595 Email: ttsh.gp@nhghealth.com.sg</p>	<div style="display: flex; align-items: center;"> ☐ Pte ☐ Sub </div> <p>Admiralty Medical Centre (AdMC) Tel: 8499 4676 Fax: 6607 8343 admc.admin@nhghealth.com.sg</p>	<div style="display: flex; align-items: center;"> ☐ Pte ☐ Sub </div> <p>Woodlands Hospital (WH) Tel: 6361 6021 Fax: 6361 1980 wh.endoscopy@nhghealth.com.sg</p>

REQUESTED PROCEDURE	
Please refer to the referral criteria and tick the indications.	☐ OGD ☐ Colonoscopy ☐ OGD & Colonoscopy

PATIENT DETAILS	
PATIENT NAME: NRIC NO:	Patient Contact Numbers (If different from sticker): <div style="display: flex; justify-content: space-around; border-top: 1px solid black; border-bottom: 1px solid black;"> (Home) (Mobile/Office) </div>

RELEVANT HISTORY	
(Please tick ☐ NIL if absent and fill in Drug Allergy section)	
MEDICAL HISTORY ☐ Diabetes Mellitus (not on Insulin) ☐ Hypertension ☐ Ischaemic Heart Disease ☐ Cerebrovascular Disease ☐ Infectious Diseases (e.g., Hep B/C, HIV) ☐ Others (pls specify): _____ ☐ Nil	DRUG ALLERGY Drug Allergy: _____ ☐ Nil <div style="background-color: #cccccc; padding: 2px;">ANTI-PLATELET AGENTS</div> <div style="display: flex; justify-content: space-between;"> ☐ Nil ☐ Clopidogrel (Plavix) </div> <div style="display: flex; justify-content: space-between;"> ☐ Aspirin ☐ Dipyridamole (Persantin) </div> <div style="display: flex; justify-content: space-between;"> ☐ Ticlopidine (Ticlid) ☐ </div> For OGD: No need to stop anti-platelets.

OGD – REFERRAL CRITERIA	
Indication(s) for OGD (please tick ☐) ☐ Recurrent upper abdominal pain / bloating ☐ Recurrent 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 OGD	
Patient Characteristics	<ul style="list-style-type: none"> Unable to open mouth wider than 3cm between the upper and lower incisors Unable to give consent < 21 years old, or > 60 years old Pregnant Difficult airway (e.g., short chin, OSA, morbid obesity) Loose tooth
Medical Conditions	<ul style="list-style-type: none"> Overt GI bleeding Uncontrolled hypertension (BP > 180/100) Severe Cardiopulmonary Disease Has cardiac device (e.g., cardiac pacemakers, defibrillators, stents, heart valve replacements) Recent AMI / CVA within 6 months Significant loss of weight
Specific Medications	<ul style="list-style-type: none"> Diabetic on Insulin On dual antiplatelet therapy On anticoagulation: warfarin and NOAC Medications (e.g., Dabigatran, Rivaroxaban, Apixaban, Edoxaban)

Patients with normal endoscopic findings will be referred to GP. Patients with biopsy done will be given SOC appointment.
 Patients with abnormal H. Pylori findings: TTSH - patients referred to GP for follow-up; KTPH & WH - patients given SOC appointment.

COLONOSCOPY – REFERRAL CRITERIA
Indication(s) for Colonoscopy (please tick ☐)

- ☐ History of per rectal bleeding
- ☐ FIT +ve
- ☐ Family history (1st degree relative) of colorectal cancer – screen at age 40 or 10 years before the youngest affected relative, whichever is earlier
- ☐ Colon polyp surveillance (based on previous instructions from endoscopist) – date of previous colonoscopy: _____ (GP to input)

Patients with these conditions are NOT suitable for Open Access Colonoscopy

Patient Characteristics	<ul style="list-style-type: none"> • Unable to give consent • < 21 years old, or > 60 years old • Pregnant • Difficult airway (e.g., e.g., previous head and neck surgery, short chin, OSA, BMI > 35) • Last Colonoscopy done within 2 years
Medical Conditions	<ul style="list-style-type: none"> • Acute GI bleeding • Abdominal pain • Significant loss of weight • Uncontrolled hypertension (BP > 180/100) • Severe Cardiopulmonary Disease • History of COPD and asthma • Severe, unstable ischaemic heart disease • Has cardiac device (e.g., cardiac pacemakers, defibrillators, stents, heart valve replacements) • Recent AMI / CVA within 6 months • Epilepsy/seizure • Progressive neurological diseases (e.g. motor neuron disease, multiple sclerosis) • Moderately severe to severe chronic kidney disease • Unable to walk independently without assistance • Mental or physical disability
Specific Medications	<ul style="list-style-type: none"> • Diabetic on Insulin • On dual antiplatelet therapy • On anticoagulation: warfarin and NOAC Medications (e.g., Dabigatran, Rivaroxaban, Apixaban, Edoxaban)

Patients with normal scope results or non-malignant histology results will be referred to GP.

Patients with critical results (e.g., malignancy) will be given SOC appointment.

MEDICATION ADVICE

(Please tick to confirm if the patient is on any of the listed medications and has received the corresponding advice)

OGD	COLONOSCOPY
☐ 4 Weeks before OGD: Stop all antibiotics including Metronidazole, Clarithromycin, Amoxicillin, Tetracycline	☐ 1 Week before Colono: Stop all anti-platelet agents (except Aspirin). Temporary increase in risk of thromboembolic phenomenon to be explained.
☐ 2 Weeks before OGD: Stop Omeprazole/ Prilosec, Lansoprazole/ Prevacid, Rabeprazole Sodium/Aciphex, Esomeprazole/ Nexium	☐ 2 Days before Colono: Stop SGLT2-I
☐ Day of OGD Procedure: Stop all diabetic medicine	☐ Day of Colono Procedure: Stop all diabetic medicine

CONSENT

- ☐ I have taken verbal consent from patient to proceed with the requested procedure(s).
Detailed consent will be taken by procedurist on procedure day.
- ☐ I have briefed patient on the requested procedure(s), preparation required and provided Patient Information Sheet(s).

REFERRAL REQUESTED BY

Dr (Stamp Name and MCR No.):	Clinic Name:
Dr's Signature:	Clinic Contact:
Date:	Clinic Email: _____

Patient Information Sheet





