gutCARE

Mount Elizabeth Novena Specialist Centre 38 Irrawaddy Road #10-58 **Tel: 6734 3435 Fax: 6734 3458**
Gleneagles Medical Centre 6 Napier Road #07-19 Singapore 258499 **Tel: 6259 7859 Fax: 6259 7839**
Parkway East Medical Centre 319 Joo Chiat Place #02-03 Singapore 427989 **Tel: 6348 0648 Fax: 63480685**
Mount Alvernia Medical Centre D 820 Thomson Road #07-55 Singapore 574623 **Tel: 6258 0508 Fax: 66258 0509**
Farrer Park Medical Centre 1 Farrer Park Station #07-10 Singapore 217562 **Tel: 6443 0708 Fax: 6443 0706**
Mount Elizabeth Medical Centre 3 Mount Elizabeth #12-01 Singapore 228510 **Tel: 6235 6651 Fax: 6235 6671**

SPECIALIZED SERVICES REFERRAL FORM

For appointments, please contact our clinics directly

Patient Particulars

Affix Patient Label

Appointment

Appointment Date : _____

Appointment Time : _____

Appointment Location : _____

Fasting From (Date/Time): _____

Mode of Payment:

☐ Bill Patient Directly

☐ Bill Referring Clinic

Please Indicate Service Required:

Please give your patients a copy of our patient information/procedure preparation.

Patient Information on test preparation are available at **website link: https://www.gutcare.com.sg/specialized-services/**

Breath Testing Studies (Please indicate)

☐ *Small Intestinal Bacterial Overgrowth (SIBO)

[Glucose **OR** Lactulose] *Please delete accordingly*

☐ *Lactose Intolerance

☐ *Fructose Intolerance

**24 hours Dietary restriction and 12 hours Fasting window to be followed strictly before procedure (to be advised by clinic staff)*

Liver Stiffness Measurement

☐ *Fibroscan

**2 hours fasting window to be followed prior to procedure*

Gastrointestinal Motility Studies

☐ Colon Transit Study

☐ *High Resolution Esophageal Manometry and 24hr pH Impedance Study (Acid Reflux Study)

☐ *High Resolution Esophagel Monometry (Motility Study Only)

***Please note for Acid Reflux and Motility Studies, please call 8809 3346 / 6259 7859 or email:**

drreubenwongkm@gmail.com for appointments

Attention to Ms. Fiqah

Please Indicate:

1) Patient's BMI: _____

2) Diagnosis: _____

Indication: (e.g. Symptoms, Underlying Illness)

Referring Doctor (Stamp/Signature/Date)

Clinic Stamp