

## SPECIALIZED SERVICES REFERRAL FORM

For esophageal motility and colonic motility appointment please call 6443 0708 or email to [clinicalsvcs@gutcare.com.sg](mailto:clinicalsvcs@gutcare.com.sg)

For fibroscan, please call 6734 3435 or email to [gcnovena@gutcare.com.sg](mailto:gcnovena@gutcare.com.sg)

| Patient Particulars                                                                                                                                                                                                                                                                                                 | Appointment                                                                                                                                                                                                                                                                                                                              |
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|                                                                                                                                                                                                                                                                                                                     | Date:                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                     | Time:                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                     | Location:                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                     | Fasting From (Date/Time):                                                                                                                                                                                                                                                                                                                |
| BMI:                                                                                                                                                                                                                                                                                                                | <b>Mode of Payment</b>                                                                                                                                                                                                                                                                                                                   |
| Diagnosis:                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Bill Patient Directly                                                                                                                                                                                                                                                                                           |
| Indication (e.g. Symptoms, Underlying Illness):                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Bill Referring Clinic                                                                                                                                                                                                                                                                                           |
| <b>Please Indicate Service Required</b><br><br>Kindly provide your patient a copy of our patient information/procedure preparation.<br>The above information are available at <a href="https://www.gutcare.com.sg/health-cat/specialised-services/">https://www.gutcare.com.sg/health-cat/specialised-services/</a> |                                                                                                                                                                                                                                                                                                                                          |
| <b>Fibroscan Liver Stiffness Measurement</b><br><input type="checkbox"/> Fibroscan with CAP<br><br><i>Note:</i><br>- Only available at <b>Gutcare Novena</b><br>- 2hrs fasting window required prior to procedure.<br>(to be advised by Clinic Staff)                                                               | <b>Esophageal Motility Studies</b><br><i>Note: 6 hrs fasting required prior to procedure (to be advised by Clinic Staff)</i><br><br><input type="checkbox"/> High Resolution Esophageal Manometry and 24hrs pH Impedance Study (Acid Reflux Study)<br><br><input type="checkbox"/> High Resolution Esophageal Manometry (Motility Study) |
|                                                                                                                                                                                                                                                                                                                     | <b>Constipation Colonic Motility Study</b><br><br><input type="checkbox"/> Colon Transit Study                                                                                                                                                                                                                                           |

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 Referring Doctor (Stamp/Signature/Date)

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 Clinic Stamp