|| LIAU KH SPECIALIST CLINIC

Dr Liau Kui Hin
MBBS, M.Med(Surgery), FRCS(Ed), FAMS(Surgery)

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Patient Sticker Label

(Name, NRIC, Date of Birth and Contact Number)

DIRECT ACCESS ENDOSCOPY FORM – REFERRAL FORM

GENERAL PRACTITIONER CLINIC LOCATION DETAILS

CLINIC STAMP:

Doctors Name: ______________________

Address: ______________________

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Tel: ______________________

Fax: ______________________

Dr Signature: ______________________

PROCEDURE REQUIRED & CURRENT DIAGNOSIS
(please tick accordingly)

GASTROSCOPY ☐ **COLONOSCOPY** ☐ **GASTROSCOPY & COLONOSCOPY** ☐

Preferred Date: ______________________

Diagnosis / Indications:

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Past Medical History:

IDDM / NIDDM	YES ☐	NO ☐
Renal Insufficiency	YES ☐	NO ☐
Cirrhosis / Liver Disease	YES ☐	NO ☐

Others: ______________________

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Medication:

ASPIRIN / PLAVIX	YES ☐	NO ☐
WARFARIN	YES ☐	NO ☐

Others: ______________________

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Drug Allergy:

NO ☐

YES ☐ **If yes, please indicate:** ______________________

Recent Lab Result or Other Relevant Test Result:

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