Patient Name_____ DOB_____

NORTON
WEIGHT MANAGEMENT
SERVICES

NORTON HEALTHCARE

BARIATRIC SURGERY PATIENT PACKET

Send completed information to:
Norton Weight Management Center
1000 Dupont Rd.
Louisville, KY 40207
PHONE: 502.899.6500
FAX: 502.895.2675
Email: WeightManagement@nortonhealthcare.org

Patient Name_____ DOB_____

Welcome to Norton Weight Management Services. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are many steps leading up to surgery, so we have developed a team to help you. It is very important that you take an active role during the process before and after surgery. Your effort will ensure the process moves as efficiently as possible.

In order to provide you with the best possible service, we must have the following information on file before scheduling your appointment in the Bariatric Center. Please use this sheet as a checklist for your items.

- ☐ **The Bariatric Center Patient Packet: Complete all forms** and provide all necessary information to take the next steps in the program.

- ☐ **Insurance cards:** Include copies of **any/all** insurance cards, front and back.

- ☐ **Medical Records:** Ask your doctor for the last 12 months of your medical records. These are the notes in your chart that the doctor makes during your visit. Ask your doctor for copies of your medical records that support your history of obesity and any diseases you have been treated for that are related to obesity.
  Reminder: Many insurance companies require <u>a six-month (or other specified period of time) physician supervised medical weight management program</u> before surgery is approved. This means you will need to see your doctor every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement. Inquire to your insurance representative to determine if you have to do this.

- ☐ **Physician letters of support:** Ask your primary care physician or any other physicians you have seen, such as cardiologists, pulmonologists, orthopaedic specialists, obstetricians/gynecologists, to write a letter of support. (**See sample letter on page 10**.)

- ☐ **Behavioral Health Information Form:** To be filled out by the person prescribing any medications you take for anxiety, depression, mood disorder, etc. This form needs to be completed even if you are prescribed psychiatric medication for a different medical reason, for example, sleep, fibromyalgia, neuropathy, etc. **(Form is located on page 11.)**

If you choose, you may provide a personal letter explaining your medical condition and how your weight affects your life – physically, mentally, financially, etc. Please bring the completed packet, copies of your insurance cards, medical records and letters with you when you attend an information seminar, or send the information to the address below. If you have any questions, call the Bariatric Center at (502) 899-6500. We look forward to assisting you!

Patient Name_____ DOB_____

Send completed information to:
Norton Weight Management Center
1000 Dupont Rd.
Louisville, KY 40207
FAX: (502) 895-2675
Email: WeightManagement@nortonhealthcare.org

FINANCIAL INFORMATION

As your health care provider, we are concerned not only with your physical well-being, but also with your peace of mind. We understand that making financial arrangements for health care services can be stressful. That's why we want to help.

We have created this document so you may be fully prepared for your financial responsibility as it relates to your desired surgery. Norton Healthcare facilities and physician practices do require collection of patient financial responsibility prior to your surgery or appointments. Patient responsibilities include deductibles, co-payments, co-insurance, and self-pay payments.

For example, if your insurance plan is an 80/20 plan, meaning your insurance company agrees to pay 80% of covered charges and you are responsible for the remaining 20%, you will be required to pay any applicable co-payment as well as your co-insurance amount of 20%.

We do have resources you can use to estimate your patient financial responsibility. You may request an estimate by visiting www.nortonhealthcare.com, and clicking on patients and visitors, then the billing information center link. You may then click on the hospital billing link to submit an online request for pricing estimates.

Or, you may call our hospital billing team.
Patients with insurance and bariatric benefits/coverage: (502) 272-5341 (8 a.m. to 5 p.m.)

You will need to know your deductible amount, your coinsurance plan (80/20, 90/10 etc.) as well as the CPT code for your procedure. Common CPT codes for bariatric surgery include:

Procedure	**CPT Code**
Laparoscopic Adjustable Gastric Banding	43770
Laparoscopic Gastric Bypass	43644
Open Gastric Bypass	43846
Laparoscopic Sleeve Gastrectomy	43775

For more information: Contact once surgery has been scheduled.

Women and Childrens-St Matthews Hospital Financial Counselor: (502)899-6207 or (502)899-6136

Patient Signature: _____ **Date:** _____

Patient Name_____ DOB_____

TODAY'S DATE_____

LAST NAME _____ FIRST NAME_____ MI_____ SUFFIX _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NO.: _____

RACE: (For Multi-racial choose all that apply)

☐ African American ☐ Caucasian ☐ Native American or Alaska Native ☐ Other

☐ Asian ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander

GENDER: ☐ Male ☐ Female

Marital Status: [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] DIVORCED

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ WORK #: *_____ EXT: _____

CELL #: _____ FAX #: _____ E-MAIL: _____

*** MAY WE CONTACT YOU AT YOUR WORK NUMBER?_____**

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired

☐ Disabled – if yes, please provide reason for disability _____ ☐ Unemployed

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE INFORMATION

NAME: _____ DOB: _____

EMPLOYER: _____ EMPLOYER PHONE NO.: _____

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NO.: _____ ADDRESS: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NO.: _____ ADDRESS: _____

Patient Name_____ DOB_____

INSURANCE INFORMATION

PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH FRONT & BACK, WHEN SUBMITTING THIS FORM

Disclaimer:

- **Norton Weight Management Services is not responsible for incorrect information that the insurance company may provide to you.**
- **Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.**
- **Completion of this form also does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by a bariatric surgeon.**

PLEASE PRINT CLEARLY

Fill in this information.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	
Provider Telephone Numbers (listed on back of card)	

Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved. This means you will need to see your doctor every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) do not meet this requirement.

We will verify if your policy includes a medically supervised weight loss requirement and communicate this information to you. You may call the customer service number listed on your card to determine if you need this, and begin seeing your doctor every month for six months to help speed the process along. ***We do recommend that you contact the customer service number on your card in order to better understand the benefits specific to your insurance policy. Submission for approval for surgery does not occur until after the surgeon consult, and all required information is submitted to the insurance company.***

Some insurance policies have contract exclusions which mean that weight loss surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying that it is not covered in your contract and they will not pay for it.

If you have questions regarding your insurance, please contact the Bariatric Center at (502) 899-6500.

Patient Name _____ DOB _____

#	Question for Representative	Answer from Representative
1	Please look in my current certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary? Do I have a requirement to complete a medically supervised weight management program? If so, how long does it have to be? Do I have to go to a Blue Distinction Center?	
2	Please have the representative read the benefit or exclusion to you. Write it down word for word. Ask that a copy be sent to you via mail or fax.	
3	What is the effective date of my policy?	
4	What is the calendar year renewal date?	
5	Is a referral required?	
6	What is the deductible per calendar year?	
7	How much have I met towards my deductible?	
8	What is the maximum out of pocket per calendar year?	
9	How much have I met towards my maximum out of pocket?	
10	Is the deductible applied to the maximum out of pocket?	
11	What is the co-insurance precert for my policy?	
12	What is my inpatient surgical copay to the doctor?	
13	What is my outpatient surgical copay to the doctor?	
14	What is my inpatient surgical copay to the hospital?	
15	What is my outpatient surgical copay to the hospital?	
16	What is my outpatient diagnostic copay to the hospital (routine labs and x-rays)?	
17	What is my copay for a specialist office visit?	
18	What is the fax number for pre-determination?	
19	What is the phone number for the precertification department?	
20	Name of the representative.	
21	Date you spoke to representative.	

Diagnosis code:	Morbid obesity	E66.01		
CPT codes:	Lap Gastric Banding	43770	Lap Gastric Sleeve	43775
	Lap gastric bypass	43644	Open gastric bypass	43846

Patient Name_____ DOB_____

PLEASE CHECK BELOW IF YOU HAVE A SURGEON PREFERENCE

[ ] NORTON WOMEN AND CHILDREN HOSPITAL

[ ] JEFFREY W. ALLEN, M.D.

[ ] BEN TANNER, M.D.

[ ] NO SURGEON PREFERENCE/FIRST AVAILABLE

IF YOU MARKED A SURGEON, PLEASE TELL US WHY:

[ ] Physician Referral [ ] Word of Mouth [ ] Website

[ ] Other _____

PLEASE CHECK THE SURGERY IN WHICH YOU ARE INTERESTED

[ ] ROUX-en-Y GASTRIC BYPASS

[ ] LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING

[ ] SLEEVE GASTRECTOMY

[ ] REVISION OF PREVIOUS BARIATRIC SURGERY

DO YOUR REQUIRE ANY DEVICE OR ASSISTANCE WITH AMBULATION

[ ] NONE [ ] CANE [ ] WALKER [ ] WHEELCHAIR [ ] SCOOTER

DO YOU HAVE ANY COMMUNICATION CONCERNS WE SHOULD BE AWARE OF

[ ] ENGLISH AS A SECOND LANGUAGE [ ] DIFFICULTY HEARING

[ ] NEED A TRANSLATOR? [ ] NEED AN INTERPRETER?

[ ] OTHER_____

Patient Name_____ DOB_____

BARIATRIC FEE FOR NON-COVERED SERVICES

You will be required to pay a **one-time, non-refundable fee of $300.00 to Norton Healthcare**. **This fee is not billed to insurance**. The $300.00 fee covers

- review of your medical history by professionals in the Bariatric Center
- verification of your benefits regarding weight loss surgery
- your initial assessment at the Bariatric Center (approximately a 2 hour visit, including individual consultation with a bariatric nurse, dietitian and mental health professional)
- educational materials
- life-time post procedure support from our team of nurses, dietitians and mental health professionals, including support groups and individual consultation

Payment will be due at the time of registration. You are responsible to obtain any REFERRAL from your primary care physician if you have an HMO and/or your insurance requires REFERRALS. Norton Healthcare will reschedule or cancel appointments pending payment of applicable fees and insurance. **This fee does not include any additional fees that may be charged when you see your surgeon.** This fee also does not guarantee insurance approval for your surgery through your surgeon's office.

SCHEDULING POLICY FOR NORTON HEALTHCARE BARIATRIC CENTER

To make the best use of your time and to meet the needs of all of our patients, we require that appointments be scheduled with our staff and we expect you to keep your appointments and to be on time. Failure to be on time could result in rescheduling of your appointment. We understand circumstances may require you to reschedule your appointment. Please contact our office at least 24 hours before your appointment to cancel and reschedule. Failure to cancel your appointment with 24 hours notice may result in rescheduling problems. Your cooperation in scheduling and keeping appointments will be greatly appreciated.

Please check and sign below.

☐ I have read and understand the above statements related to the Bariatric Program Fee and the Scheduling Policy.

☐ Signature:_____Date:_____

Norton Healthcare

Medical History for Bariatric Surgical Assessment

The questions asked on the following pages are very important. Please fill out the packet completely. The information you provide will be used by your surgeon's office to submit your case to insurance for approval of your surgery. Thank you.

SAMPLE PHYSICIAN LETTER OF SUPPORT

Patient Name_____ DOB_____

Please obtain a letter of support from your primary care physician.

This form is a sample only and will not be accepted if the blanks are completed. Your physician must provide a separate letter of support.

Attn: Referring Physician – If your patient is prescribed any type of psychiatric medication, even if for non-psychiatric conditions, please indicate this by completing the Behavioral Health Information Form, and you may include a sentence within this letter of support. Example: The patient is prescribed Cymbalta for treatment of fibromyalgia only. We appreciate your assistance in helping your patient provide all necessary documentation to the insurance company in order to obtain approval for surgery.

Date

PHYSICIAN NAME
ADDRESS
CITY, STATE , ZIP CODE

RE: PATIENT NAME
DATE OF BIRTH:

To Whom It May Concern:

The above named patient has been seen by our office for (_____) years. (He/she) suffers from the following co-morbidities: (List any diseases related to obesity such as hypertension, diabetes, sleep apnea, degenerative joint disease, etc.) (His/her) current weight is (____lbs), height: (_____) and BMI: (_____). The patient has undergone the following weight loss attempts: (List any previous attempt, including Weight Watchers, Jenny Craig, Nutri-system, Slim Fast, etc., or any therapies you have prescribed).

I feel this patient would benefit from weight loss surgery because (he/she) has been unsuccessful losing weight with other diet methods, and (his/her) medical conditions will become life threatening if (he/she) does not get (his/her) weight under control.

I appreciate your consideration. Please contact me for further questions.

Sincerely,

Physician Name

Patient Name_____ DOB_____

BEHAVIORAL HEALTH INFORMATION FORM

The following form needs to be filled out by the professional prescribing mental health medications. Our goal is to work with treating professionals to accurately evaluate patients prior to bariatric surgery. Not all patients meet criteria for bariatric surgery, based on psychiatric diagnoses. An important aspect is to assess whether patients are compliant with treatment and ready for the lifestyle changes after surgery.

Patient Name _____, DOB _____,is currently in treatment with me.

The patient is being treated with the following mental health medication(s):

_____

_____

1. **Medical Diagnosis**: _____
   If the patient is taking a medication specifically for medical reasons, NOT mental health (ex. Fibromyalgia, neuropathy, sleep, etc.)

2. **Mental Health Professional only**: (Psychiatrist, Ph.D., Psy.D, LCSW, Psych-APRN)
   Axis I _____
   _____
   Axis II _____
   _____

To be completed by any or all medical professionals.
In my opinion, this patient is (please fill out all three)

1. mentally stable yes_____no_____,
2. compliant with treatment yes_____no_____,
3. and has the cognitive and emotional ability to undergo bariatric surgery and to follow aftercare recommendations yes_____no_____.

Comments:
_____

Signed: _____ Date: _____

Print name: _____ Phone: _____

Address: _____

_____

Please indicate **credentials** or medical **specialty** _____

PLEASE RETURN THIS FORM BY FAX: 502.895.2675
NORTON WEIGHT MANAGEMENT CENTER

Patient Name_____ DOB_____

Physician Information	
Referring or Primary Care Physician Name:	**Phone:**
Address/City/State/Zip	**FAX:**

Please list any other physicians whose care you are under.

	Name	Address/City/State/Zip	Phone
Cardiologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Pulmonologist			
Therapist			
Other			

Reminder:** If your insurance company requires **a six month physician supervised medical weight management program** before surgery is approved, your family physician can assist you with this. In order to complete this program, you will need to have **monthly** appointments with your physician, and a documented treatment plan in your medical records that includes height, weight and discussion/recommendations for diet and exercise plan. You must complete these monthly appointments continuously for the amount of time your insurance policy requires. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement. ***Sample forms for your physician to complete are included at the back of this patient packet.

Patient Name_____ DOB_____

PREVIOUS WEIGHT LOSS SURGERIES?

If Yes, please provide the following information:

PROCEDURE	YEAR	SURGEON	HOSPITAL

PREVIOUS SURGERIES

☐	Acid Reflux procedure	☐	Appendectomy	☐	Breast Biopsy
☐	Nissen (Stomach wrapping procedure)	☐	Gallbladder removal	☐	Breast Mastectomy
☐	Peripheral Vascular procedure	☐	Colon or Small Intestine Surgery	☐	Cesarean section
☐	Heart Bypass Surgery	☐	Hernia Surgery	☐	Tubal ligation
☐	EGD (endoscopy)	☐	Back Surgery	☐	Vasectomy

If you checked any previous surgery above, please provide the following information:

PROCEDURE	YEAR	SURGEON	HOSPITAL

<u>Did you have any complications with any previous surgery?</u> (i.e.., Blood Clots, Infections, Respiratory, Blood pressure problems) If so, please list:

<u>ANESTHESIA HISTORY:</u>

Have you ever had general anesthesia?..... Yes No

Have you ever had any problems with anesthesia? …….. Yes No Explain_____

Have you ever had radiation therapy?..... Yes No

Patient Name_____ DOB_____

CURRENT MEDICATIONS: **(Prescription, over-the-counter, vitamins, herbal, etc.) PLEASE PRINT**

MEDICATION	STRENGTH	FREQUENCY	REASON

Please circle

Multi-Vitamin Calcium Calcium w/Vitamin D Vitamin B-12 Vitamin D Vitamin A/D/E Combo Iron

ANY ADDITIONAL MEDICATIONS, PLEASE LIST ON BACK OR ATTACH SEPARATE SHEET

****

ALLERGIES:

DO YOU HAVE A LATEX OR SILICONE ALLERGY? YES NO DON'T KNOW

ALLERGIES TO MEDICINES:

_____

_____

ALLERGIES TO FOOD:

_____

_____

Patient Name_____ DOB_____

HEIGHT _____ WEIGHT _____

****

REVIEW OF SYSTEMS – PLEASE CIRCLE ALL THAT APPLY

Constitutional

Fever
Chills
Weight Loss
Fatigue
Weakness

Skin

Rash
Itching

HENT

Headaches
Hearing Loss
Nose Bleeds
Congestion

Eyes

Blurred Vision
Double Vision

Cardiovascular

Chest Pain
Palpitations
Leg Swelling
Shortness of Air Lying Down

Respiratory

Cough
Cough up blood
Shortness of Breath
Wheezing

Gastrointestinal

Heartburn
Nausea
Vomiting
Abdominal pain
Diarrhea
Constipation
Blood in Stool

Genitourinary

Difficulty Urinating
Urgency
Frequency
Urinate Blood

Musculoskeletal

Muscle Pain
Neck Pain
Back Pain
Joint Pain

Endo/Hemo/Allergy

Easy Bruise/Bleeding
Environmental Allergies

Neurological

Dizziness
Tremor
Seizures

Psychiatric

Depression
Suicidal Ideas
Substance Abuse
Hallucinations
Nervous/Anxious
Insomnia
Memory Loss
History Suicide Attempts

Patient Name_____ DOB_____

Additional Information

Do you have pain or difficulty swallowing?..... Yes No

Have you had Ulcers?..... Yes No

Blood clots in legs or lungs in the past?..... Yes No

Are you currently taking a blood thinner?..... Yes No

Bleeding Disorder……. Yes No

Anemia…….. Yes No

Previous Hiatal Hernia…… Yes No

Reflux/GERD…… Yes No

High Blood Pressure……. Yes No

Previous Heart Attack…….. Yes No

Angina (Chest Pain)……. Yes No

High Cholesterol…… Yes No

CHF (Congestive Heart Failure)……. Yes No

CAD (Coronary Artery Disease)……. Yes No

Asthma…….. Yes No

Diabetes…….. Yes No

Fatty Liver…….. Yes No

Arthritis…….. Yes No

Have you ever had kidney stones?..... Yes No

Willing to accept blood products? (red blood cells, platelets, etc.) Yes No

Sleep Apnea…… Yes No

Have you had a Sleep Study Completed?..... Yes No

Are you using or should you use? CPAP BiPAP Oxygen

Patient Name_____ DOB_____

FOR FEMALES ONLY:

Do you have regular periods? (26-33 days)……Yes No
If no, please describe_____

Could you be pregnant?..... Yes No
Last period_____

Number of pregnancies _____ Number of children _____ Miscarriages _____

Is there a chance you may get pregnant in the future?..... Yes No

Do you currently have problems with infertility…… Yes No

Have you suffered from excess body hair…….. Yes No

Have you suffered from excess acne…… Yes No

SOCIAL HISTORY

SMOKING HISTORY:
Have you ever smoked cigarettes, e-cigarettes or vaped?..... Yes No

Do you use e-cigarette/vape (with or without nicotine)?..... Yes No

Are you currently smoking (cigarettes/e-cig, or vape)?..... Yes No

If you are a smoker of any of the above, how many years have you smoked? _____

Number of pack(s) per day _____

If you previously smoked, and have quit, how long have you been cigarette free? _____

ALCOHOL CONSUMPTION: YES / NO FREQUENCY: _____ HOW MUCH PER WK? _____

HISTORY OF SUBSTANCE ABUSE? YES / NO
(Alcohol, marijuana, cocaine, iv drugs, etc.)

IF YES, GIVE DETAILS OF TREATMENT:

WHEN? _____ WHERE? _____

Patient Name_____ DOB_____

FAMILY HISTORY

	Mother	Father	Siblings (please indicate brother or sister)	Other Relatives (grandparents)
Morbid obesity				
High blood pressure				
Diabetes				
Heart disease				
Joint pain/disease				
Cancer				
If deceased, age of death/cause				

Norton Healthcare

Nutrition-Related History for Bariatric Surgical Assessment

Patient Name_____ DOB_____

How many years have you been overweight? _____ Were you overweight as a child? _____

Is your weight mostly located in your: _____Face _____Abdomen _____ Hips
_____Arms/Legs _____All

Please Check and Provide Information For All That Apply

Medically Supervised Diet Programs:

	# of Attempts	**Date(s)**	Length of Time	Weight Loss	Regained?
Medi-Fast					
Opti-Fast					
Fen/Phen					
Redux					
Meridia					
Behavior Modification					
Hypnosis					
Dietitian Recommended					

Non-MD Supervised Program:

	# of Attempts	**Date(s)**	Length of Time	Weight Loss	Regained?
Weight Watchers					
Nutri-Systems					
Jenny Craig					
Other:_____					

Liquid Diets:

	# of Attempts	**Date(s)**	Length of Time	Weight Loss	Regained?
Slimfast					
Other: _____					

Miscellaneous Diets:

	# of Attempts	**Date(s)**	Length of Time	Weight Loss	Regained?
Low Calorie Diet					
Low Fat Diet					
High Protein Diet/Low Carb Diet: (Atkins, South Beach, Zone)					
Self Imposed Fasts					
Pritikin					
Richard Simmons					
Metabolife					
Herbal Life					

Please list ANY other attempts that you have made to lose weight that are not listed:

Patient Name_____ DOB_____

Have you ever before had a "stomach stapling" procedure or other gastric surgery? _____
If yes, please describe the surgery: _____

What was your greatest single weight loss in pounds? _____

How did you lose the weight? _____

How long did you sustain that weight loss? _____

Are you currently under a Physician's care for weight loss? _____
Physician's Name: _____
Address/Phone: _____

Do you get any physical activity? _____If yes, how much and what activity?
_____

Do you eat three meals per day? _____Do you snack between meals- if so, what do you snack on?
_____

What are your favorite foods/foods you crave?
_____
_____

Do you eat large meals (gorge)? _____Do you eat a lot of sweets? _____

Do you drink fluids regularly during the day? _____ What do you drink? _____

Do you drink soda pop? _____ Is it regular or diet? _____ How many/day?_____
Do you drink alcohol? _____ What do you drink? _____How many/day? _____
How many/week? _____

Do you ever make yourself vomit after eating- how often?_____
If yes, when was the last time you made yourself vomit after eating? _____

Do you have any restrictions on your current diet? If so, what is restricted and why?
_____
_____

How often do you eat out per week? _____ How often is it fast food/fried food? _____

What change do you think is most needed to succeed after surgery?
Diet? _____Explain_____
Exercise? ____Explain_____

Patient Name_____ DOB_____

FOOD DIARY

Please list all food or drink eaten for <u>THREE</u> days and return with completed packet

Food/Beverage Consumed	Date and Time	Method of Preparation	Portion Size	Where you ate and what you were feeling

Must be completed by ALL patients

Norton Healthcare

Psychological History for Bariatric Surgical Assessment

Please note: Some insurance companies require patients to have psychological evaluations with specific types of professionals. If this is the case, we will inform you. We will also provide the names of professionals so you can call and schedule a separate appointment. You will still need to also meet with the professionals at the Norton Weight Management Center.

Patient Name_____ DOB_____

PSYCHOLOGICAL PROFILE

How long have you been considering bariatric surgery? _____

How did you research the surgery? _____

Have you ever forced yourself to vomit after overeating? _____

Have you ever forced yourself to vomit to lose weight? _____
If yes, when was the last time you forced yourself to vomit to lose weight?_____

Do you eat in response to boredom, stress, fatigue, tension, depression, anger, anxiety or loneliness?
_____

Do you eat because the opportunity is there, even when you are not hungry? _____

Do you eat as a result of negative self-worth? _____

Do you eat in response to physical cues (for example: increased hunger due to skipping meals
or eating to cure headache or other pain)? _____

What words best describe what food means to you (check all that apply):
Survival_____ Comfort_____ Energy_____ Love_____

Companionship_____ Calming_____ Other (specify) _____

Who can you count on to provide you with emotional and physical support while you are in the hospital for surgery and after you go home during the weight loss process:

_____

Have you **ever** been treated for psychiatric problems (depression, anxiety, bipolar disorder, schizophrenia)?
yes____no____

Have you ever been to the emergency room for psychiatric problems? _____

If so when? _____

Have you ever been hospitalized for psychiatric problems? _____

If so when? _____

Are you currently seeing a psychiatrist? _____

Are you currently seeing a counselor? _____

Are you currently taking medications (antidepressants, anti-psychotics, anti-anxiety, mood stabilizers) for psychiatric problems? _____

Patient Name_____ DOB_____

If so please list these medications: _____

_____

What is the name of the professional prescribing these medications? _____

If you are currently taking psychiatric medications, please have the professional treating you with medications or counseling fill out and return to the Norton Bariatric Center the attached form entitled <u>Behavioral Health Information Form (page 11)</u>. If you are not prescribed psychiatric medications, but see a counselor, please have that professional complete the form. Even if you are taking psychiatric medications for a condition other than mental health (ex: sleep, fibromyalgia, neuropathy), please have the prescribing person complete the form and return this to Norton Weight Management Center.

Do you take more of your medication than prescribed? _____
If so which medications_____

Do you take recreational drugs (street drugs or medications prescribed for someone else)?
_____ If so which drugs?_____

Have you ever been a victim of:

Sexual abuse _____
Physical abuse _____
Emotional abuse _____
Other abuse _____

If yes to above please briefly explain:
_____

<u>Please check the following symptoms you are **now** experiencing</u>:

_____Anxiety
_____Depression
_____ Current suicidal thoughts
_____Current homicidal thoughts
_____Sleep problems (if checked please indicate: too much_____, too little____)
_____Loss of energy
_____Appetite problems (if checked please indicate: too much_____, too little____)
_____Guilty thoughts
_____Loss of interest in usual activities
_____Difficulty in concentrating
_____Feelings of worthlessness
_____Feelings of helplessness
_____Feelings of being too high or speeded up
_____Confusion

Patient Name_____ DOB_____

_____Hearing voices or seeing things other people do not see
_____Feeling physically keyed up
_____Feeling someone is trying to harm me
_____Feeling someone is controlling me
_____Anger or hostility to others

Please check any of these stressors that are **currently** bothering you:

_____Job
_____Move
_____Separation or divorce (yours)
_____Divorce or separation of someone close to you
_____Death of a loved one
_____Your physical condition
_____Physical condition of a loved one

Conflicts with:
_____Offspring
_____Parents
_____Spouse
_____Neighbors
_____Co-worker
_____Boss

_____Sexual problems
_____Legal problems
_____Other stressors

Do you have ADD/ADHD or any other learning difficulty which requires special instructions for this surgical process?_____

If so please describe what you will need: _____

Patient Name_____ DOB_____

NORTON
WEIGHT MANAGEMENT
SERVICES

Medically Supervised Weight Loss Request Letter

Dear Colleague,

Patient: _____, DOB: _____ is being seen for consideration of bariatric surgery, either laparoscopic adjustable gastric banding or Roux-en-Y gastric bypass. From our assessment and in compliance with the National Institute of Health (NIH) criteria this patient meets all basic criteria for consideration, however, at this time the patient's insurance is requiring your patient to undergo _____ consecutive months of physician supervised and documented weight loss prior to being eligible for surgical services. While we understand that most patients have a long history of unsuccessful weight loss management for numerous reasons, we must comply with their guidelines.

Enclosed you will find a simple assessment form to be completed on each medical visit. We hope this form will make assessing your patient easier as well as provide consistency in fulfilling the insurance requirements to expedite your patient's surgical needs.

Simply complete the enclosed form and fax back to us at **(502) 895-2675** each month the patient visits your practice.

If you have any questions or comments, please do not hesitate to contact us.

Sincerely,

The Norton Weight Management Services Team
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6500

Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 1

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

Norton Weight Management Services
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Louisville, KY 40207
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FAX: (502) 895-2675

Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 2

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

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Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 3

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

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Louisville, KY 40207
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FAX: (502) 895-2675

Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 4

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

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Louisville, KY 40207
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FAX: (502) 895-2675

Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 5

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

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Louisville, KY 40207
(502) 899-6500
FAX: (502) 895-2675

Patient Name_____ DOB_____

Physician Supervised Weight Loss Visit – Month 6

Patient Name: _____Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary
Program:_____
_____
_____

Physical Activity/Exercise
Program:_____
_____
_____

Behavioral
Interventions:_____
_____
_____

Consideration of or use of Pharmacotherapy w/FDA approved medication if
appropriate:_____
_____
_____

Addition Comments and/or
recommendations:_____
_____
_____
_____

Physician Signature: _____ Date: _____

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