

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: 502-899-6405
FAX: 502-899-6407

Email: WeightManagement@nortonhealthcare.org

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 **a six-month (or other specified period of time) 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) 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) 899-6405. 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) 899-6407

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:

<u>Procedure</u>	<u>CPT Code</u>
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) 899-6405.

#	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 YOU 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 _____

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.

It is also recommended that you confirm with your insurance company your coverage for the initial assessment day of evaluation/education. The codes are as follows: Dietitian (initial) - 97802 + G0270 and therapist (initial) – 90791. Once you contact your insurance, please call the price estimate line at (502) 272-5330 for more specific pricing info. Prices given are an estimate and not a guarantee of your final cost responsibility.

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 Scheduling Policy.

Signature: _____ Date: _____

Patient Name _____

DOB _____

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.

Patient Name _____

DOB _____

SAMPLE PHYSICIAN LETTER OF SUPPORT

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 _____

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

<input type="checkbox"/> Acid Reflux procedure	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Breast Biopsy
<input type="checkbox"/> Nissen (Stomach wrapping procedure)	<input type="checkbox"/> Gallbladder removal	<input type="checkbox"/> Breast Mastectomy
<input type="checkbox"/> Peripheral Vascular procedure	<input type="checkbox"/> Colon or Small Intestine Surgery	<input type="checkbox"/> Cesarean section
<input type="checkbox"/> Heart Bypass Surgery	<input type="checkbox"/> Hernia Surgery	<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> EGD (endoscopy)	<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Vasectomy

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

PROCEDURE	YEAR	SURGEON	HOSPITAL

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

ANESTHESIA HISTORY:

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 _____

HEIGHT _____

WEIGHT _____

REVIEW OF SYSTEMS – PLEASE CIRCLE ALL THAT APPLY

Constitutional

Eyes

Gastrointestinal

Endo/Hemo/Allergy

Fever

Blurred Vision

Heartburn

Easy Bruise/Bleeding

Chills

Double Vision

Nausea

Environmental Allergies

Weight Loss

Vomiting

Fatigue

Cardiovascular

Abdominal pain

Neurological

Weakness

Chest Pain

Diarrhea

Dizziness

Palpitations

Constipation

Tremor

Skin

Leg Swelling

Blood in Stool

Seizures

Rash

Shortness of Air Lying Down

Itching

Genitourinary

Psychiatric

Difficulty Urinating

Depression

HENT

Respiratory

Urgency

Suicidal Ideas

Headaches

Cough

Frequency

Substance Abuse

Hearing Loss

Cough up blood

Urinate Blood

Hallucinations

Nose Bleeds

Shortness of Breath

Nervous/Anxious

Congestion

Wheezing

Musculoskeletal

Insomnia

Muscle Pain

Memory Loss

Neck Pain

History Suicide Attempts

Back Pain

Joint Pain

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
<u>Willing to accept blood products? (red blood cells, platelets, etc.)</u>	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				

Patient Name _____

DOB _____

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 _____

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 Behavioral Health Information Form (page 11). 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:

Please check the following symptoms you are **now** experiencing:

_____ 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 _____



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) 899-6407** 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) 899-6405

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
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407

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:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407

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:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407

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:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407

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:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407

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:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6405
FAX: (502) 899-6407