Patient Name: _____Date of Birth:_____
(Last) (First)

NORTON
WEIGHT MANAGEMENT
SERVICES

Norton Healthcare

Weight Loss Surgery Patient Package

Send completed information to:
Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
Phone: **(502) 899-6500**
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Welcome to Norton Weight Management Services. We want to help you in your weight loss journey. We know there are many steps leading to surgery, so we have put together a team to help you. It is very important that you take an active role before and after surgery. Your effort will help the process move 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. Use this sheet as a checklist for your items.

☐ **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 doctors you have seen, such as cardiologists, pulmonologists, orthopedic 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 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 **(502) 899-6500**. We look forward to assisting you!

Send completed information to:
Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

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. Norton Healthcare facilities and physician practices 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 percent of covered charges and you are responsible for the remaining 20 percent, you will be required to pay any applicable copayment as well as your co-insurance amount of 20 percent.

We have resources you can use to estimate your patient financial responsibility. You may request an estimate by visiting **NortonHealthcare.com** and clicking on the Pay Your Bill tab, which directs you to the Billing Information Center. You may then click on the Hospital Billing Information link to submit an online request for pricing estimates.

Or you may call our hospital billing team.

- Patients with insurance with or without weight loss benefits: **(502) 272-5330** (8 a.m. to 5 p.m.)
- Patients without insurance coverage: **(502) 485-4866** (7 a.m. to 3:30 p.m.)

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

Procedure	**CPT Code**
Laparoscopic adjustable gastric banding	43770
Laparoscopic gastric bypass	43644
Open gastric bypass	43846
Laparoscopic sleeve gastrectomy	43775

Contact once surgery has been scheduled:

_____Norton Women's & Children's Hospital financial counselor: **(502) 899-6207** or **(502) 899-6136**

Patient signature: _____ Date: _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Today's date:_____

Last name: _____ First:_____ Middle initial: _____ _____

Date of birth: _____ Age: _____ Social Security number: _____

Race/ethnicity: (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: _____

Home phone: _____ Work phone: *_____ EXT: _____

Cell: _____ Fax: _____ Email: _____

*** May we contact you at your work number? _____**

Employment information

Status:
☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Unemployed** ☐ **Student** ☐ **Retired**

☐ **Disabled (If yes, provide reason for disability) _____**

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

Spouse information

Name: _____ Birthdate: _____

Employer: _____ Employer phone: _____

Emergency contacts

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Insurace information

Attach copies of front and back of all insurance cards when submitting this form.

Disclaimer

- Norton Weight Management Services is not responsible for incorrect information 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 percent 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 when filling in this information.	
Patient's name	
Patient's date of birth	
Insurance name	
ID number	
Group number	
Subscriber's name	
Subscriber's employer	
Subscriber's date of birth	
Provider's telephone numbers (listed on back of insurance 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 a 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 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, it is simply saying that it is not covered in your contract and it will not pay for it.

If you have questions regarding your insurance, call Norton Weight Management Services at **(502) 899-6500.**

Patient Name: _____Date of Birth:_____
(Last) (First)

#	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?	
2	Please read the benefit (or exclusion) to me. 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 toward my deductible?	
8	What is the maximum out of pocket per calendar year?	
9	How much have I met toward my maximum out of pocket?	
10	Is the deductible applied to the maximum out of pocket?	
11	What is the co-insurance precertification 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 (X-rays and routine labs)?	
17	What is my copay for a specialist office visit?	
18	What is the fax number for predetermination?	
19	What is the phone number for the precertification department?	
20	What is the 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: _____Date of Birth:_____
(Last) (First)

Check if you have a surgeon preference:

Norton Women's & Children's Hospital

[ ] Jeffrey W. Allen, M.D.

[ ] Meredith C. Sweeney, M.D.

[ ] Benjamin D. Tanner, M.D.

[ ] No surgeon preference/first available

If you marked a surgeon, tell us why:

[ ] Physician referral [ ] Word of mouth [ ] Website
[ ] Other: _____

Check the surgery in which you are interested:

[ ] Roux-en-Y gastric bypass

[ ] Laparoscopic adjustable gastric banding

[ ] Sleeve gastrectomy

[ ] Revision of previous weight loss surgery

Do you require a device or assistance in getting around?

[ ] 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 (writing) [ ] Need an interpreter (speaking)

[ ] Other: _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Fee for services not covered by insurance

You will be required to pay a **one-time, nonrefundable fee of $300 to Norton Healthcare**. **This fee is not billed to insurance**. The $300 fee covers:

- Review of your medical history by professionals in Norton Weight Management Services
- Verification of your benefits regarding weight loss surgery
- Your initial assessment at Norton Weight Management Services (approximately a two-hour visit, including individual consultation with a nurse, dietitian and mental health professional)
- Educational materials
- Lifetime 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 for obtaining a 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.

Norton Weight Management Services scheduling policy

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. If you must cancel or reschedule, contact our office at least 24 hours before your appointment. Failure to cancel your appointment with 24 hours' notice may result in rescheduling problems.

Check and sign below.

☐ I have read and understand the above statements related to the fee and the scheduling policy.

☐ Signature: _____ Date: _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Norton Healthcare

Medical History for Weight Loss Surgery 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.

Patient Name: _____Date of Birth:_____
(Last) (First)

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 filled in. Your physician must provide a separate letter of support.

Referring physician: If your patient is prescribed any type of psychiatric medication, even if for nonpsychiatric conditions, please complete 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's name
Address
City, state, ZIP

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 (____ pounds), height: (_____) and BMI: (_____). The patient has undergone the following weight loss attempts: (List any previous attempt, including Weight Watchers, Jenny Craig, Nutrisystem, SlimFast, 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's name

Patient Name: _____Date of Birth:_____
(Last) (First)

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 weight loss surgery. **Not all patients meet criteria for weight loss 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 (example: 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. Has the cognitive and emotional ability to undergo weight loss surgery and to follow aftercare recommendations Yes _____ No _____.

Comments:
_____

Signed: _____ Date: _____

Print name: _____ Phone: _____

Address: _____

_____

Credentials or medical specialty: _____

Return this form by fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Norton Weight Management Services

Physician information	
Referring or primary care physician name:	**Phone:**
Address, City, State, ZIP:	**Fax:**

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 a 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: _____Date of Birth:_____
(Last) (First)

Have you had previous weight loss surgeries?
If yes, 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
☐	Upper GI endoscopy (EGD)	☐	Back surgery	☐	Vasectomy

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

Procedure	Year	Surgeon	Hospital

Did you have any complications with any previous surgery? (e.g., blood clot, infections, respiratory issue, blood pressure problem) If so, list them:

Patient Name: _____Date of Birth:_____
(Last) (First)

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

Current medications (prescription, over-the-counter, vitamins, herbal, etc.)
Please print clearly.

Medication	Strength	Frequency	Reason

Please circle:
Multivitamin Calcium Calcium with vitamin D Vitamin B-12 Vitamin D Vitamin A/D/E combo Iron

List any additional medications on back or attach a separate sheet.

****

Allergies:

Do you have a latex or silicone allergy? Yes No Don't know

Patient Name: _____Date of Birth:_____
(Last) (First)

Allergies to medicines:

Allergies to food:

Height _____ Weight _____

Review of systems

Constitutional
Fever
Chills
Weight Loss
Fatigue
Weakness

Eyes
Blurred vision
Double vision

Cardiovascular
Chest Pain
Palpitations
Leg Swelling
Shortness of air lying down

Skin
Rash
Itching

Head and ENT
Headaches
Hearing Loss
Nosebleed
Congestion

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

Blood/allergies
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: _____Date of Birth:_____
(Last) (First)

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
Congestive heart failure.…….…….	Yes	No
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
Sleep apnea……	Yes	No
Have you ever had a sleep study?.....	Yes	No
Are you using or should you use? CPAP BiPAP oxygen		

Patient Name: _____Date of Birth:_____
(Last) (First)

Women

Do you have regular periods? (26 to 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:
Have you ever smoked cigarettes?..... Yes No

Do you use e-cigarette?..... Yes No

Do you currently smoke?..... Yes No

If you are a smoker, how many years have you smoked? _____

Number of packs per day: _____

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

Do you consume alcohol?: Yes / No Frequency: _____ How much per week? _____

Do you have a history of substance abuse? Yes No
(Alcohol, marijuana, cocaine, intravenous drugs, etc.)

If yes, give details of treatment:

When? _____ Where? _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Family history

	Mother	**Father**	**Siblings (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: _____Date of Birth:_____
(Last) (First)

Norton Healthcare

Nutrition-related History for Weight Loss Surgery Assessment

Patient Name: _____Date of Birth:_____
(Last) (First)

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

Check and provide information for all that apply

Medically supervised diet programs

	No. of attempts	Date(s)	Length of time	Weight loss	Regained?
Medifast					
Optifast					
Fen/phen					
Redux					
Meridia					
Behavior modification					
Hypnosis					
Dietitian recommended					

Non-medically supervised program

	No. of attempts	Date(s)	Length of time	Weight loss	Regained?
Weight Watchers					
Nutrisystem					
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					

Patient Name: _____Date of Birth:_____
(Last) (First)

List any other attempts you have made to lose weight that are not listed:

Have you ever 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? _____ 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 or fried food? _____

What change do you think is most needed to succeed after surgery?
Diet? _____ Explain:_____
Exercise? ____ Explain:_____

Patient Name: _____Date of Birth:_____
(Last) (First)

Food diary

List all foods and drinks you've consumed for **three** 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

The food diary must be completed by all patients.

Patient Name: _____Date of Birth:_____
(Last) (First)

Norton Healthcare

Mental Health History for Weight Loss Surgery Assessment

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 also will provide the names of professionals so you can schedule an appointment. You still will need to meet with the professionals at the Norton Weight Management Services.

Patient Name: _____Date of Birth:_____
(Last) (First)

Mental health profile

How long have you been considering weight loss 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 (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 for 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 a mental health condition? _____

If so, when? _____

Have you ever been hospitalized for a mental health condition?_____

If so, when? _____

Are you currently seeing a psychiatrist? _____

Are you currently seeing a counselor? _____

Patient Name: _____Date of Birth:_____
(Last) (First)

Are you currently taking medications (antidepressants, antipsychotics, anti-anxiety, mood stabilizers) for mental health conditions? _____

If so, list these medications: _____

_____

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

If you currently are taking psychiatric medications, have the professional treating you with medications or counseling fill out the Behavioral Health Information form (page 11) and return it to Norton Weight Management Services. If you are not prescribed psychiatric medications but see a counselor, have that professional complete the form. Even if you are taking psychiatric medications for a condition other than mental health (i.e.: sleep, fibromyalgia, neuropathy), have the prescribing person complete the form and return this to Norton Weight Management Services.

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 any of the above, briefly explain:
_____

Check the following symptoms you are **now** experiencing:

_____ Anxiety
_____ Depression
_____ Suicidal thoughts
_____ Homicidal thoughts
_____ Sleep problems (Too much_____ Too little____)
_____ Loss of energy
_____ Appetite problems (Too much_____ Too little____)
_____ Guilt
_____ Loss of interest in usual activities
_____ Difficulty concentrating
_____ Feelings of worthlessness
_____ Feelings of helplessness

Patient Name: _____Date of Birth:_____
(Last) (First)

_____Feelings of being too high or speeded up
_____Confusion
_____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 attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD) or any other learning difficulty that requires special instructions for this surgical process?
_____

If so, describe what you will need: _____

Patient Name: _____Date of Birth:_____
(Last) (First)

NORTON
WEIGHT MANAGEMENT
SERVICES

Medically Supervised Weight Loss Request Letter

Dear colleague,

Patient: _____, DOB: _____ is being seen for consideration of weight loss 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 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,

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 1

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 2

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 3

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 4

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:
_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 5

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**

Patient Name: _____Date of Birth:_____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 6

Patient name: _____Date: _____

DOB: _____ Physician: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current dietary program:_____
_____
_____

Physical activity/exercise program:_____
_____
_____

Behavioral interventions:_____
_____
_____

Consideration of or use of pharmacotherapy with FDA-approved medication, if appropriate:_____
_____
_____

Additional comments and/or recommendations:_____
_____
_____

Physician signature: _____ Date: _____

Norton Weight Management Services
1000 Dupont Road
Louisville, KY 40207
(502) 899-6500
Fax: **(502) 895-2675**