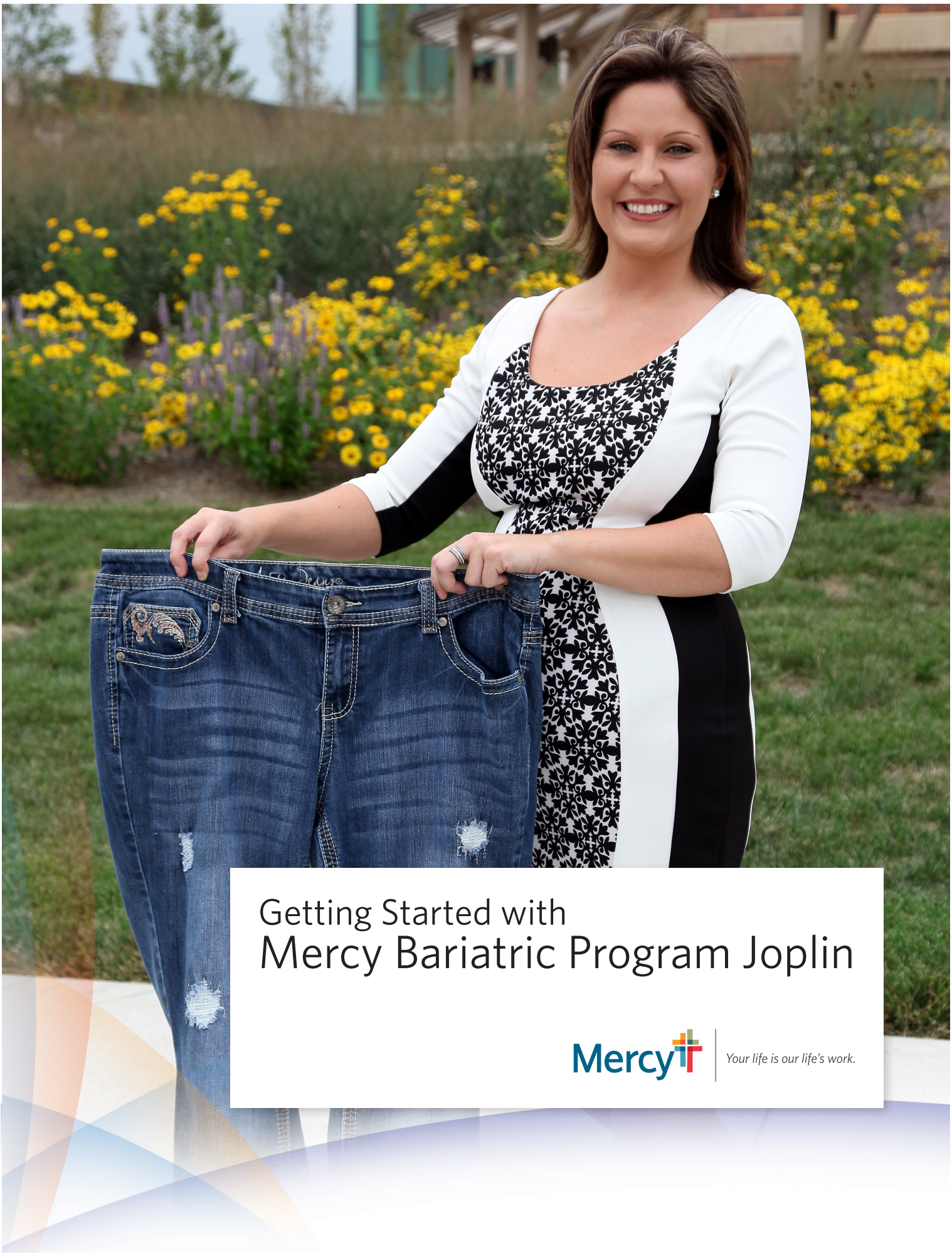

Getting Started with
Mercy Bariatric Program Joplin

Mercy

Your life is our life's work.

JPN_31854 (8/23/23)

Mercy Bariatric Center

Requirements to Initiate Consultation

1) **Carefully read entire contents of packet**

2) **Check for insurance coverage for the procedure with your carrier**
   - Please include a copy of the front and back of your insurance card(s) with the returned materials.
   - Our nurse coordinator can assist you with this process if you have questions.
   - We also have information on finance options and institutions that can help provide this service if needed.

3) **Completely fill out the Patient History/Profile Section**

4) **Obtain a referral letter from Primary Care Physician**
   - To include height, weight, BMI, health problems, previous weight loss attempts, etc.(form included in packet)

5) **Sign the Medical Release Form**
   - Make sure to provide the name and address of your primary care physician. We will need this to communicate with your primary care physician and expedite your care.

6) **If you are not being seen by a Mercy physician, obtain all pertinent health records for the last 3 years.**
   - Please mail them with your packet or ask the doctor's office to fax them to 417-781-5845 – Attn. Mercy Bariatric Program Coordinator.
   - If you have had any of the following tests, please include results- EKG, stress test, sleep study, MRI, CT scan.
   - Include Operative notes (from previous abdominal surgeries)
   - Make every effort to get all the records you can – the information contained in them can make the difference in the eyes of your insurance company!

7) **Return the completed paperwork to our office**
   - We then review your information and schedule your initial evaluation appointment with our bariatric surgeon.
   - Include copy of the FRONT and BACK of your insurance card(s).

8) **Make sure your information is labeled with your full name and date of birth**
   - Make a copy of you completed packet, keep the copy for yourself and send or bring us the original.
   - While the criteria are designed to be applied to all patients, we do consider each patient as an individual and we will evaluate you in this way.

Contact number for Mercy Bariatric Program Coordinator: **417-556-2915**. They will be glad to answer your questions and assist you by coordinating your care as you prepare for weight loss surgery.

Mercy Bariatric Center

Patient Registration

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____
LAST FIRST MIDDLE

SEX: M or F MARITAL STATUS: S M D W X (please circle one) SOCIAL SECURITY NO.: _____

HOME ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PERSONAL EMAIL ADDRESS: _____ YOUR PHARMACY: _____

YOUR PRIMARY CARE PHYSICIAN: _____ WHO SENT YOU TO SEE US? _____

EMPLOYER: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ BIRTHDATE: _____ SS#: _____

HOME ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SPOUSE'S EMPLOYER: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ OCCUPATION: _____

NAME OF PRIMARY INSURANCE: _____ ID# _____ GROUP# _____

INSURED'S NAME: _____ BIRTHDATE: _____ SS#: _____

INSURED'S ADDRESS: _____ CITY/STATE/ZIP: _____

INSURED'S RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURED'S EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

CITY/STATE/ZIP: _____ OCCUPATION: _____

NAME OF SECONDARY INSURANCE: _____ ID# _____ GROUP# _____

INSURED'S NAME: _____ BIRTHDATE: _____ SS#: _____

INSURED'S ADDRESS: _____ CITY/STATE/ZIP: _____

INSURED'S RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURED'S EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

CITY/STATE/ZIP: _____ OCCUPATION: _____

Mercy Bariatric Center

Medical Information Release / HIPAA Form

Do we have your permission to:

Leave a message on your cellular phone?	___ Yes	___ No	___ Do Not Have One
Leave a message on your answering machine at home?	___ Yes	___ No	___ Do Not Have One
Leave a message at your place of employment?	___ Yes	___ No	___ Not Employed
Discuss your medical condition with other members of your family or friends?	___ Yes**	___ No	

** If YES, please list below the name(s) of the people & their relationship to you. Please list your spouse and/or other family or friends who may call our office. If you do not list anyone, Dr. Liu and his staff CANNOT discuss your medical information with anyone but you.

I, _____, give permission to Dr. Liu and/or his staff to release information (verbal or written) about me, my medical condition and/or treatment to the following person(s):

NAME OF PERSON (Please Print)	RELATIONSHIP TO PATIENT	TELEPHONE NO.
_____	_____	Home# _____
		Cell# _____
_____	_____	Home# _____
		Cell# _____
_____	_____	Home# _____
		Cell# _____
_____	_____	Home# _____
		Cell# _____

I understand that I may rescind this release at any time and will do so in writing.

*** I also acknowledge that I have been given the Office Privacy Notice.***

_____ _____

Patient's or Legal Guardian's Signature Date

Mercy Bariatric Center

Confidential Medical History Form – Please Print (Page 1 of 4)

Patient's Name: _____ DOB _____ Date: _____

PAST MEDICAL HISTORY: Please list any medical conditions you have or had (i.e. High Blood Pressure, Diabetes, Heart Condition, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST SURGICAL HISTORY: (If more lines are needed, please continue on the back.)

SURGERY / YEAR	SURGERY / YEAR
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

DO YOU HAVE ANY IMPLANTED MEDICAL DEVICES?

___ Pacemaker ___Portacath ___ Orthopedic Hardware ____Lens (cataract)

___ Other (explain) _____

MEDICATIONS YOU ARE TAKING: Include over-the-counter, aspirin, herbals, etc. (If more lines are needed, please continue on the back.)

DRUG NAME.	DOSE/MG.	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ARE YOU ALLERGIC TO LATEX? ___ YES ___NO Reaction: _____

ANY PROBLEMS WITH ANESTHESIA? _____

Mercy Bariatric Center

Confidential Medical History Form – Please Print (Page 2 of 4)

Patient's Name: _____ DOB _____ Date: _____

ARE YOU ALLERGIC TO ANY MEDICATION(S)? ____ YES (List below) ____ NO

DRUG / AGENT TYPE OF REACTION

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY:

HEIGHT _____ CURRENT WEIGHT_____

DO YOU SMOKE? _____ PACKS PER DAY _____ FOR _____ YEARS

IF YOU SMOKED IN THE PAST, WHEN DID YOU QUIT? _____

ALCOHOL CONSUMPTION: HOW MUCH _____ HOW OFTEN _____ __

RECREATIONAL/STREET DRUGS: TYPE _____ HOW OFTEN _____

YOUR LAST FLU SHOT _____ PNEUMOVAX _____TETANUS _____

DO YOU WEAR (CIRCLE ALL THAT APPLY) GLASSES CONTACTS DENTURES HEARING AIDES

DO YOU EXERCISE? TYPE _____ HOW OFTEN _____

FAMILY HEALTH HISTORY: Please indicate relatives who have or had this disease.

HEART DISEASE _____

HIGH BLOOD PRESSURE _____

STROKE _____

DIABETES _____

BLEEDING DISORDER _____

KIDNEY DISEASE _____

CANCER (type) _____

REVIEW OF SYSTEMS: Please mark any of the following conditions you have now or have had in the past.

CONSTITUTIONAL:

____ Fevers ____ Chills ____ Unexpected weight change ____ Malaise/Fatigue ____ Diaphoresis ____ Weakness

____ Other (explain): _____

SKIN CONDITIONS:

___ Rashes ____ Itching ____ Other (explain): _____

Mercy Bariatric Center

Confidential Medical History Form – Please Print (Page 3 of 4)

Patient's Name: _____ DOB _____ Date: _____

HENT:

_____ Headaches ____ Hearing Loss ____ Tinnitus/ringing in ears ____ Ear Pain
____ Ear Discharge ____ Nosebleeds ____ Congestion ____ Stridor/wheezing
____ Sore throat ____ Other (explain): _____

EYE:

____ Blurred vision ____ Double vision ____ Photophobia/sensitivity to light ____ Eye pain
____ Eye discharge ____ Eye redness
____ Other (explain): _____

CARDIOVASCULAR:

____ Chest pain/Angina ____ Palpitations ____ Orthopnea/difficult breathing lying down
____ Claudication/leg cramping ____ Leg swelling ____ PND
____ Other (explain): _____

RESPIRATORY/BREATHING PROBLEMS:

____ Cough ____ Hemoptysis/bloody sputum ____ Sputum production ____ Shortness of breath
____ Wheezing ____ Other (explain): _____

GASTROINTESTINAL PROBLEMS:

____ Heartburn ____ Nausea ____ Vomiting ____ Abdominal Pain
____ Diarrhea ____ Constipation ____ Blood in Stools ____ Melena/tarry stools
____ Other (explain): _____

GENITOURINARY PROBLEMS:

____ Dysuria/painful urination ____ Urgency ____ Frequency
____ Hematuria/bloody Urine ____ Flank pain
____ Other (explain): _____

MUSCULOSKELETAL (BONE/JOINT) PROBLEMS:

____ Myalgias/muscle pain ____ Neck pain ____ Back Pain ____ Arthralgias/joint pain
____ Falls ____ Other (explain): _____

ENDO/HEME/ALLERGY:

____ Bruise/ Bleed easily ____ Environmental allergies ____ Polydipsia/excessive thirst
____ Other (explain): _____

Mercy Bariatric Center

Confidential Medical History Form – Please Print (Page 4 of 4)

Patient's Name: _____ DOB _____ Date: _____

NEUROLOGICAL

____ Dizziness ____ Tingling ____ Tremors ____ Sensory change

____ Speech change ____ Focal weakness ____ LOC/loss of conscience

____ Other (explain): _____

PSYCHIATRIC/EMOTIONAL PROBLEMS:

____ Depression ____ Suicidal ideas ____ Substance abuse ____ Hallucinations

____ Nervous/anxious ____ Insomnia ____ Memory loss

____ Other (explain): _____

PLEASE LIST ANY PROBLEM /CONDITION YOU HAVE OR HAD THAT WAS NOT ALREADY MENTIONED:

_____

_____

_____

HAVE YOU HAD ANY RECENT TESTING (WITHIN 6 MONTHS):

WHEN / WHERE

Blood work _____

EKG _____

Echocardiogram (heart ultrasound) _____

X-rays/CT Scans _____

Carotid (neck) doppler/ultrasound: _____

Leg doppler/ultrasound: _____

MRI or MRA: _____

Mercy Bariatric Center

Weight Information

Patient's Name: _____ DOB _____ Date: _____

NEUROLOGICAL

Current Weight: _____ Max. Weight: _____ Lowest Adult Weight: _____ Height: _____

Date of Max. Wt: _____ Date of lowest Weight: _____ BMI: _____

How would you describe your current weight? _____

_____

_____

At what weight have you felt your best or think you would feel your best? _____

_____

How does your weight affect your daily activities? _____

_____

Why do you want to lose weight? _____

_____

_____

Why are you considering surgery to help you lose weight? _____

_____

_____

How do you think your life would change if you reach your weight goal? _____

_____

_____

Age when you first remember being overweight: _____

Age when you first began dieting: _____

MEDICATION PRESCRIBED BY A PHYSICIAN FOR WEIGHT LOSS

Medications may be listed as both generic and name brand. Check the one prescribed to you

❑ Acutrim	❑ Obalan	❑ Stacker 2	❑ Adipex-P
❑ Orlistat	❑ Coritslim	❑ Anorex	❑ Phentermine
❑ Ephedrine	❑ Dexatrim	❑ Phentrol	❑ Relacore
❑ Dexfenfluramine	❑ Pondimin	❑ Didrex	❑ Redux
❑ Fastin	❑ Sanorex	❑ Fenfluramine (FenFEN)	❑ Tepanol
❑ Ionamin	❑ Topamax	❑ Mazanor	❑ Tenuate
❑ Meridia	❑ Xenical	❑ Other _____	❑ Other _____

Mercy Bariatric Center

Weight Loss History

Patient's Name: _____ DOB _____ Date: _____

Most insurance companies require documented evidence of previous weight loss attempts, so it is very important that you complete this in detail.

METHOD	AGES	TIMES TRIED	WEIGHT LOST	COMMENTS/WEIGHT REGAIN
Weight Watchers				
TOPS				
First Place				
Nutri-System				
Jenny Craig				
LA Weight Loss				
Richard Simmons				
Overeaters Anonymous				
Herbal Life				
Dietitian				
Slim Fast				
Liquid Diet				
Cabbage Soup Diet				
Mayo Clinic Diet				
Scarsdale Diet				
Atkins				
South Beach Diet				
Sugar Buster				
High Carbohydrate, Low Fat				
Starvation				
Behavior Modification				
Psychotherapy				
Hypnosis				
Surgery				
Diet Books				
Calorie Counting				
Dr. Vitkins				
Dr. Jagiella				
Dr. Martin				
Exercise				
Other (Please describe)				

Mercy Bariatric Center

Social History

Patient's Name: _____ DOB _____ Date: _____

DO YOU USE TOBACCO CURRENTLY? _____ HOW MANY PACKS/DAY? _____

HOW MANY YEARS HAVE YOU SMOKED? _____ HAVE YOU TRIED TO QUIT? _____

DID YOU SMOKE IN THE PAST? _____ HOW MANY PACKS/DAY? _____

HOW MANY YEARS DID YOU SMOKE? _____ WHEN DID YOU QUIT? _____

DO YOU DRINK BEER, LIQUOR, OR WINE? _____ HOW MANY GLASSES PER WEEK? _____

DO YOU USE ANY RECREATIONAL DRUGS? _____ WHICH ONE(S)? _____

HAVE YOU EVER HAD AN ADDICTION TO DRUGS? _____

Sleep History

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Please fill out the box below.

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (a theater, or in a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Mercy Hospital Joplin | Joplin, MO

Date and tme received: _____

Authorization for Release of Medical Record Information

I hereby grant my permission for release of medical information for a period of (5) five years from the date of my signature below relating to my care from and to the following parties:

To: Mercy Bariatric Program
Danny Liu, MD
100 Mercy Way, Suite 440
Joplin, MO 64804

Phone number: 417-781-4404
Fax number: 417-781-5845

From: (for patient's Doctor's office only)
_____
_____
_____

Phone number: _____
Fax number: _____

The purpose of this Authorization for Release of Information is to provide continuity of my health care, for processing insurance claims or to meet another specific desire of mine. THIS INFORMATION MAY include treatment or rehabilitation of DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, PSYCHOLOGICAL, AIDS AND'OR HIV TESING OR GENETIC TESSING INFORMATION if they do occur.

PLEASE PRINT

PATIENT'S LEGAL NAME: _____ DOB: _____ SOCIAL SECURITY # _____

PATIENT'S ADDRESS: _____CITY _____ STATE _____ ZIP _____

I SPECIFY THAT THIS AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION INCLUDE THE FOLLOWING

❏ Final Diagnosis
❏ Operative Reports
❏ Pathology
❏ ENTIRE RECORD
❏ Discharge Summary
❏ X-ray Reports
❏ Progress Notes
❏ Other _____
❏ History/Physical
❏ Laboratory Reports
❏ Physician Orders
❏ Consultation Reports
❏ EKG
❏ Emergency Room Record/ Date

I UNDERSTAND THE FOLLOWING:

- Authorization may be withdrawn in writing at any time.
- Recipients of my information are forbidden from re-disclosure without my specific authorization.
- A facsimile may be utilized with the same effectiveness as the original.

SIGNATURE OF PERSON
AUTHORIZING RELEASE: _____ Date Signed: _____

WITHNESS SIGNATURE: _____ Date Signed: _____

IF THE ABOVE SIGNATURE IS NOT THAT OF THE PATIENT, EXPLANTION WILL BE PROVIDED BELOW AND DOCUMENTARY EVIDENCE OF GUARDIANSHIP MAY BE REQUIRED TO ACCOMPANY THIS AUTHORIZATION:

_____

_____

_____

Mercy Bariatric Center

Letter of Referral for Weight-Loss Surgery

Mercy Bariatric Program
Mercy Bariatric Center - Joplin
100 Mercy Way | Suite 440
Joplin, MO 64804
Phone: 417-781-4404
Fax: 417-781-5845

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE NO: _____ _____

INSURANCE COMPANY/PLAN/NUMBER: _____

HEIGHT: _____ WEIGHT: _____ BMI: _____

The patient above is a patient of mine with a long history of obesity that has been refractory to medical weight loss regimens. The patient's obesity related comorbidities include:

Please check any of the following medical concerns that should be investigated further prior to the patient starting an exercise or diet program and undergoing general anesthesia for weight loss surgery.

	Present in this patient?	**Further workup needed prior to Bariatric Surgery?**
Bleeding or clotting disorders		
Cardiac problems		
Pulmonary problems (including sleep apnea)		
Lupus or any other connective tissue or autoimmune disease		
Recent or frequent steroid use		
Previous weight loss or anti-reflux surgery		
Diabetes (Last HgA1C= ____) (HbA1C must be < 8 before surgery)		
Smoking (must quit before surgery)		
Active drug/alcohol/narcotic use		
Psychiatric illness		
Repeated no-shows for scheduled office visits /noncompliance		
Any other concerns?		

IF CONSIDERED AN APPROPRIATE SURGICAL CANDIDATE, (PLEASE CHECK ONE):

( ) This patient would benefit from consideration for weight-loss surgery in order to improve his or her overall health, quality of life, and to minimize their risk of obesity related co-morbidities.

( ) This patient is medically optimized for surgery.

( ) I will need to see the patient back again in the office for formal preoperative clearance.

Is the patient medically able to start an exercise or diet program? Yes or No

PHYSICIAN'S SIGNATURE: _____ Date Signed: _____

Mercy continues the tradition of the Sisters of Mercy in meeting community health needs across a seven state area.