Getting Started with Mercy Clinic Bariatric Surgery

Mercy

Your life is our life's work.

STL_36557 (2/27/19)

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. **Obtain all pertinent health records *for the last three to five years* (depending on insurance requirement) from your primary care physician and other treating physicians**
   - Please ***mail*** them with your packet or ask the doctor's office to ***fax*** them to ***314.251.7249.***
   - 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 in St. Louis, MO**
   - Mail to: 621 S. New Ballas Rd., Tower B, Suite 7011B, St. Louis, MO 63141
     OR send by fax: 314.251.7249
   - 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.

Please give our office a call if you have any questions: 314.251.6840. We will be glad to answer your questions and assist you by coordinating your care as you prepare for weight loss surgery.

Patient Registration

Today's Date: _____

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: _____ 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: _____ Address: _____

City/State/Zip: _____ Occupation: _____

PHI Communication Form

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ Last 4 digits of SSN: _____

_____ Telephone: _____

I, _____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

_____	_____	_____
Printed Name	Relationship to Patient	Telephone
_____	_____	_____
Printed Name	Relationship to Patient	Telephone
_____	_____	_____
Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: _____ Date: _____
Signature

Patient or Legal Personal Representative: _____
Printed Name

Authority of Personal Representative: _____

Patient Name:
MRN#:
Date of Birth:

Mercy

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. _____

(If more lines are needed, please continue on the back.)

PAST SURGICAL HISTORY:

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

(If more lines are needed, please continue on the back.)

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.

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

(If more lines are needed, please continue on the back.)

ARE YOU ALLERGIC TO LATEX? ☐ **YES** ☐ **NO** **Reaction:** _____

ANY PROBLEMS WITH ANESTHESIA? _____

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

Patient's Name:_____ DOB: _____ Date: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** *(List below)* ☐ **NO**

	Drug/Agent	**Type of Reaction**
1.		
2.		
3.		
4.		
5.		

(If more lines are needed, please continue on the back.)

SOCIAL HISTORY:

Height: _____ Current Weight: _____

Do you use tobacco currently?_____ How many packs/day? _____

How many years have you smoked?_____ Have you tried to quit? _____

Did you use tobacco 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? _____

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):_____

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

Patient's Name:_____ DOB: _____ Date:

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

SKIN CONDITIONS:	
☐ Rashes	☐ Itching
☐ Other (explain):	
Have you ever had MRSA infection: ☐ Yes ☐ No When?	

CONSTITUTIONAL:		
☐ Fevers	☐ Chills	☐ Unexpected weight change
☐ Malaise/Fatigue	☐ Diaphoresis	☐ Weakness
☐ Other (explain):		

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):		
Have you been diagnosed with High Blood Pressure: ☐ Yes ☐ No		
Have you seen a Cardiologist: ☐ Yes ☐ No		
Ever have a abnormal EKG? ☐ Yes ☐ No		
Other heart test? ☐ Yes ☐ No Type of Test:		
Do you take heart medication: ☐ Yes ☐ No		

RESPIRATORY/BREATHING PROBLEMS		
☐ Cough	☐ Hemoptysis/Bloody Sputum	☐ Sputum Production
☐ Shortness of Breath	☐ Wheezing	☐ History of Asthma
☐ Other (explain):		
Ever been diagnosed with COPD or Emphysema? ☐ Yes ☐ No		
Recent lung test or studies: ☐ Yes ☐ No Test done:		

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

Patient's Name:_____ DOB: _____ Date: _____

GASTROINTESTINAL PROBLEMS: Ever been told you have a:		
☐ Hiatal Hernia	☐ Gastric Ulcer	☐ H-Pylori
☐ Heartburn	☐ GERD (Gastroesophageal Reflux)	☐ Abdominal Pain
☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Constipation	☐ Blood in Stools	☐ Melena/Tarry Stools
☐ Other (explain):		
When were you told?		
Have you ever had an esophagogastroduodenoscopy (EGD)? ☐ Yes ☐ No		
Have you ever had a Upper GI Xray test (UGI)? ☐ Yes ☐ No		
What did they show?		
If you have heartburn or reflux, how many times a week?		
Do you take medication for any of the above? ☐ Yes ☐ No Over the Counter Med:		

GENITOURINARY PROBLEMS:		
☐ Dysuria/Painful Urination	☐ Urgency	☐ Frequency
☐ Hematuria/Bloody Urine	☐ Flank Pain	☐ Incontinence
☐ Other (explain):		

MUSCULOSKELETAL (BONE/JOINT) PROBLEMS:		
☐ Myalgias/Muscle Pain	☐ Neck Pain	☐ Back Pain
☐ Arthralgias/Joint Pain	☐ Falls	☐ Fibromyalgia
☐ Other (explain):		

ENDO/HEME/ALLERGY		
☐ Bruise/Bleed Easily	☐ Environmental Allergies	☐ History of DVT (blood clot)
☐ Polydipsia/Excessive Thirst	☐ History of Pulmonary Emoboli	☐ History of Anemia
☐ Other (explain):		
Ever been diagnosed with Diabetes? ☐ Yes ☐ No		
Last Hgb A1C? Result?		
Medication for Diabetes: ☐ Insulin ☐ Oral Medication ☐ Diet Only		

NEUROLOGICAL:		
☐ Dizziness	☐ Tingling	☐ Tremors
☐ Sensory Change	☐ Speech Change	☐ Focal Weakness
☐ LOC/Loss of Consciousness	☐ TIA	
☐ 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:

_____

_____

Weight Information

Patient's Name:_____ DOB: _____ Date: _____

Current Weight: _____ Max. Weight: _____ Lowest Adult Weight: _____
Height: _____ Date of Max. Wt: _____ Date of lowest Weight: _____
BMI: _____

How would you describe your current weight?_____
_____

What is a reasonable weight loss goal? _____

How does your weight affect your daily activities? _____
_____

Why do you want to lose weight? _____
_____
_____

If you do not lose weight, how will your health be in 5 years? _____
_____
_____

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

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

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

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
Surgery				
Weight Watchers				
Nutri-System				
Jenny Craig				
Dietitian				
Slim Fast				
Liquid Diet (opti or medifast)				
Atkins				
Starvation				
Behavior Modification				
Psychotherapy				
Hypnosis				
Diet Books				
Calorie Counting				
TOPS				
Richard Simmons				
Overeaters Anonymous				
Herbal Life				
First Place				
LA Weight Loss				
Cabbage Soup Diet				
Mayo Clinic Diet				
Scarsdale Diet				
South Beach Diet				
Sugar Buster				
High Carbohydrate, Low Fat				
Other *(please describe)*				

Patient's Name:_____ DOB: _____ Date: _____

HAVE YOU HAD ANY RECENT TESTING *(within past year)*:

TYPE	WHEN	WHERE
Blood work		
EKG		
Echocardiogram *(Heart Ultrasound)*		
X-rays/CT Scans		
Carotid *(neck)* Doppler/Ultrasound		
Leg Doppler/Ultrasound		
MRI or MRA		

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				

Have you had a Sleep Study in the past? ☐ Yes ☐ No Date done: _____

Have you been diagnosed with Sleep Apnea: ☐ Yes ☐ No

Do you use a CPAP or BiPAP? ☐ Yes ☐ No Setting: _____

Mercy Hospital
St. Louis, Missouri

Date & Time Received: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I HEREBY GRANT MY PERMISSION FOR RELEASE OF MEDICAL INFORMATION FOR A PERIOD OF (3-5) THREE-FIVE YEARS FROM THE DATE OF MY SIGNATURE BELOW RELATING TO MY CARE FROM AND TO THE FOLLOWING PARTIES:

TO: Mercy Clinic Bariatric Surgery
Matthew Lange, DO
621 S. New Ballas Rd. | Tower B | Suite 7011B
St. Louis, MO 63141
Phone #: 314.251.6840
Fax #: 314.251.7249

FROM: _____
_____
_____
_____
Phone #: _____
Fax #: _____

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 TESTING OR GENETIC TESTING INFORMATION if they do occur.

PLEASE PRINT

Patient's Legal Name: _____

Date of Birth: _____ Social Security #: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

I specify that this authorization for release of medical record information include the following:

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

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.

I also give permission for my health care team to communicate and share information regarding my health.

Signature of Person
Authorizing Release: _____ Date Signed: _____

Withness Signature: _____ Date Signed: _____

If the above signature is not that of the patient, explanation will be provided below and documentary evidence of guardianship may be required to accompany this authorization:

_____

_____

Mercy Clinic Bariatric and General Surgery
Matthew Lange, DO
621 S. New Ballas Rd. | Suite 7011B | St. Louis, MO 63141
15945 Clayton Rd. | Suite 310 | Ballwin, MO 63011
314.251.6840 | Fax: 314.251.7249

Letter of Referral for Weight-Loss Surgery

Patient Name: _____ Date of Birth: _____

Address:_____City/State/Zip:_____

Phone No: _____Insurance Company/plan/number: _____

Height: _____ Weight: _____ BMI: _____

Weight History: 2019 _____ 2018 _____ 2017 _____ 2016 _____ 2015 _____

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 comorbidities.

☐ 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 ☐ No

Physician's Signature: _____ Date:_____

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