Baptist Health Medical Group – Bariatric Surgery

What Happens Next?

Once you complete and return your patient packet your information will then be reviewed to ensure you meet criteria for surgery, and to review your insurance benefits to determine required criteria to seek approval for surgery. You should hear from our office within 2 weeks of submitting your packet.

Our office is located in building B, 3900 Kresge Way, Suite 42 located on the 4th floor. Turn right off of Breckenridge Lane on to Kresge Way. Make a right at the first light in front of the hospital. You will see the 3900 building directly in front. It has a "B" and Baptist East Medical Pavilion on the building.

What Happens On My Initial Visit?

During your first visit you will see a Nurse Practitioner for a History and Physical, a Registered Dietician for a nutritional screening, the Psychologist for psychological screening, have education regarding the program, procedures and exercise. Plan to arrive at 7am and stay approximately 5-6 hours on that day. Bring any test results, recent lab work (within the past 30 days) and physician letters of support if you have them on that day. Please plan on eating nothing after midnight the evening before your visit in order to have lab work drawn on that day as well. You may have room temperature water after midnight. Please bring a snack and drink with you to have after your lab work.

Baptist Health Medical Group – Bariatric Surgery

For any questions regarding insurance concerns or for questions related to medical concerns, test results, surgical scheduling etc.; please phone our office at **502-894-9499**. **The fax office is 502-894-9595.**

Baptist Health Louisville-Weightloss/Bariatric Center

To speak with **Karen Barnett Sparks**- the Bariatric Program Coordinator- please phone **502-897-8264.** Karen can answer questions related to services provided by the program such as Support Groups, Intake appointments, etc. Please feel free to call if you have any concerns. Karen will make sure you are guided in the correct direction. **Her fax number is 502-897-8263 and her email address is karen.barnettsparks@bhsi.com.**

Thanks you for the opportunity to provide you with care.

BAPTIST HEALTH

Baptist Health Medical Group-Bariatric

Patient Information Packet

Preferred Procedure:

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ Laparoscopic Greater Curvature Plication
- ❍ Apollo Overstitch Procedure

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require: _____

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____ Patient's level of Education:_____

What is your height?_____ft _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ❍ Yes ❍ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?_____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?_____Relationship to you?_____

Spouse Information

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Baptist Surgical Associates- Bariatric to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

Have you discussed Weight Loss Surgery with your physician? ❍ Yes ❍ No is your physician supportive? ❍ Yes ❍ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Other:_____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

Blood Consent

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Weight Loss History

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet?_____lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ **NONE**

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System	❍ Overeaters Anonymous	❍ Weight Watchers	❍ Jenny Craig
❍ TOPS	❍ Optifast	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_____	

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol

❍ Redux ❍ Byetta ❍ Plegine ❍ Sanorex ❍ Meridia

❍ Xenical ❍ Diuretics ❍ Pondimin ❍ Phenteramine

❍ Fen-Phen, # of months:_____ ❍ Other:_____

Behavioral Treatments for Weight Loss: ❍ **NONE**

❍ Hospitalization ❍ Hypnosis

❍ Physical Therapy ❍ Psychological Therapy

❍ Residential Programs ❍ Other:_____

Exercise: ❍ **NONE**

❍ Walking or Running ❍ Stationary cycle or treadmill

❍ Swimming ❍ Weight Training

❍ Team Sports ❍ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

●If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

●If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness

❍ Makes me happy ❍ Bored

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

Please tell us how your weight is interfering with your health and life? _____

_____

Why are you seeking weight loss surgery? _____

_____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

Medical History/Review of Symptoms: (Check all that apply)

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:_____	

Head and Neck	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:_____

Cardiovascular	☐ **NONE**	
☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Dyspnea on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:_____

Respiratory	☐ **NONE**	
☐ Asthma	☐ Emphysema / COPD	☐ Bronchitis
☐ Pneumonia	☐ Chronic Cough	☐ Shortness of Breath at Rest
☐ Use of Cpap / Bipap	☐ Use of Oxygen	☐ Snoring
☐ Pulmonary Embolism	☐ Sleep Apnea	☐ Other:_____

Gastrointestinal	☐ **NONE**	
☐ Heartburn	☐ Hiatal Hernia	☐ Ulcers
☐ Diarrhea	☐ Blood in Stool	☐ History of Liver Enzymes
☐ Constipation	☐ IBS	☐ Umbilical Hernia
☐ Difficulty Swallowing	☐ Hemorrhoids	☐ Fissure / Polyps
☐ Rectal Bleeding	☐ Black, Tarry Stool	☐ Ventral Hernia
☐ Abdominal Pain	☐ Enlarged Liver	☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems	☐ Jaundice	☐ Pancreatic Disease
☐ Nausea / Vomiting	☐ GERD	☐ Incisional Hernia
☐ Barrett's Esophagus	☐ Other:_____	

Bladder/Kidney	☐ **NONE**	
☐ Kidney Stones	☐ Blood in Urine	☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

☐ Trouble starting urine ☐ Burning / Pain on urination ☐ Urinary Urgency/Frequency

☐ Overall Loss of Bladder Control ☐ Other:_____

Gynecologic (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post Menopausal

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram:_____

Musculoskeletal ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Other:_____

Neurologic ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudotumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression ☐ Anxiety

☐ Bipolar Disorder (“manic-depression”) ☐ Seen a Psychiatrist or Counselor

☐ Alcoholism / Substance Abuse ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attention Deficit Disorder ☐ Other:_____

Endocrine ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ “Pre-Diabetes” ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ Other:_____

Blood / Lymphatic ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Other:_____

Skin ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing

☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea

☐ Hair or Nail Changes ☐ Other:_____

List Prescribed Medications:	**Taken for what condition:**	**Dosage / How Often:**
☐ **NONE**		

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	**Taken for what purpose:**	**Dosage / How Often:**

Allergies ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

Foods (List foods and the reaction):_____

Surgical Procedure(s): ☐ **NONE**		**Year**		**Year**
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____
Hernia: ❍ Hiatal	❍ Inguinal ❍ Incisional	❍ Umbilical		
Tubal Ligation		_____	Knee: ❍ Right ❍ Left	_____
Cesarean Section		_____	Breast Biopsy: ❍ Right ❍ Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Hemorrhoidectomy		_____	Kidney Surgery	
Colon Resection		_____	Back:_____	_____
Endoscopy/EGD		_____	Other:_____	_____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____ ❍ Estimated ❍ Actual

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea ❍ Heart Stopped ❍ Woke up during procedure

❍ Vomiting ❍ Stopped Breathing ❍ Other:_____

❍ Difficulty Waking Up ❍ Difficulty Urinating

Social History

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years do/did you drink alcohol? _____Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

Could someone help care for you if you were seriously ill? ❍ Yes ❍ No Who?_____

Are there people for whom you are the primary care giver? ❍ Yes ❍ No Who?_____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before sending in your packet:

- ☐ Filled out this form as completely as possible
- ☐ Made a copy of the front and back of your insurance card
- ☐ Signed the Blood Consent
- ☐ Called your insurance and completely fill out the Insurance Review Form

Mail completed packet and Insurance Card to:

Baptist Health Medical Group
- Bariatric
3900 Kresge Way, Suite 42
Louisville, Kentucky 40207

Date Completed: _____

Insurance question contact our office
Phone: 502-894-9499
Fax: 502-894-9595

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.

3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. Once complete, return this form, along with a copy of your insurance card(s), to our office.
5. Please also make sure that you submit your patient profile packet via mail or internet.
6. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
    a. **Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. You must complete this form if you have a Medicare supplement plan, Medicare Replacement plan, or a Medicare HMO.**

Fill in this information before you call the insurance company. Please write clearly.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	☐ **Yes** (Continue with this form.) ☐ **No** (Complete #s 2, 9 & 10 then end the call.) **See explanation below
****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that 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 they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3	Do I have a Bariatric Lifetime Maximum?	
4	Am I required to have Weight Loss Surgery at a Center of Excellence facility or Blue Distinction Center?	
5	Is Baptist Health Medical Group- Bariatric (Dr. Oldham) in my network? Tax ID#: 205497203	
6	Is the facility in my network? Baptist Health Tax ID# 610444707	
7	What is the effective date of my policy?	
8	Is a referral required for specialist office visits?	
9	Name of the representative	
10	Date you spoke to representative	
	If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.	☐ **Yes** ☐ **No**

Disclaimer:

- Baptist Health Medical Group- Bariatric 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% of the charges.
- Completion of this form 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 Baptist Health Medical Group- Bariatric.

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**
- **I have read and understand the disclaimer which includes that I am not approved for surgery.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

Patient Signature: _____ **Date:** _____