Getting Started with
Mercy Bariatric Center

Your life is our life's work.

mercy.net

WSH_29110 (12/18/14)

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 ***636-861-7899 – Attn. Cathy Radford, RN, Mercy Bariatric Center 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 in Washington, MO**
   - Mail to: 851 E. 5th St., Suite 108, Washington, MO 63090
   - 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 *Cathy Radford, RN, BSN, CBN*, Mercy Bariatric Center Coordinator: 636-861-7891. She 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: ___________________________________

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. Hawver and her staff **CANNOT discuss your medical information with anyone but you.

I, ______________________________ , give permission to Dr. Hawver and/or her 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.***

X____

Patient's or Legal Guardian's Signature Date

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
Washington, 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 Bariatric Center
Lisa Hawver, MD, FACS
851 East Fifth Street, Suite 108
Washington, MO 63090
Phone #: 636-861-7891
Fax #: 636-861-7899

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 Bariatric Center
Mercy Hospital Washington
851 E. Fifth St. | Suite 108 | Washington, MO 63090
636-861-7891 | Fax: 636-861-7899
mercy.net/bariatrics

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: 2014 __________ 2013 __________ 2012 __________ 2011 __________ 2010 __________

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.