Thank you for your interest in the MUSC Bariatric Surgery Program and congratulations on your decision to pursue a lasting and effective treatment for your obesity together with our team.

**IMPORTANT:** Before you fully commit to weight loss surgery, we strongly suggest that you contact your insurance carrier to verify that weight loss surgery is a covered benefit under your policy. Some policies exclude all types of weight loss surgery. It can be extremely disappointing to find out that you do not have coverage after going through the evaluation process. So we encourage you to find out prior to submitting your application. If your insurance carrier does not cover the procedure, please call financial services at 843-876-3036 to discuss self-pay details.

Enclosed in this packet is an outline of the steps required to have surgery (keep these for your records):
- Checklist to prepare for weight loss surgery
- Insurance and financial information
- Information for your doctor/provider about ‘Medically Supervised Diet or Weight loss attempt’

Please complete and return the enclosed pages to:
- MUSC Bariatric Surgery Program
  25 Courtenay Drive, Ashley River Tower
  MSC 290
  Charleston, SC 29425 - 2900

Return these forms to us:
- Monthly Consecutive Weight Loss Attempts for Patients Preparing for Bariatric Surgery
  - This is a *sample* form for your primary care provider to complete (have provider complete for as many months as required (3-6 months) and return with your records)
- Authorization to disclose protected health information
- MUSC Bariatric Surgery Program Contract
- Patient Information form
- Initial Patient Nutrition Assessment
- New Patient Questionnaire

When we receive your packet we will be in touch with you to discuss next steps. Please visit our website for more information and resources [www.muschealth.org/weight-loss-surgery](http://www.muschealth.org/weight-loss-surgery)

Yours sincerely,

The MUSC Bariatric Surgery Team
Karl Byrne, MD, Medical Director, Professor of Surgery
Rana Pullatt, MD, Director of Robotic Surgery, Associate Professor of Surgery
Aaron Lesher, MD, Assistant Professor of Surgery and Pediatrics

Program phone: 843-792-3046
Program fax: 843-876-4201
Checklist to Prepare for Weight Loss Surgery (Keep this page for your records)

This checklist is a guide to assist you in the process of having bariatric surgery at MUSC. The checklist should be done in order. There are further details to each of these steps on the following pages titled “Steps to Weight Loss Surgery.” If your insurance company denies coverage for your procedure, you are responsible for all charges associated with the pre-operative work-up. **This is why it is imperative you contact your insurance company to verify weight loss surgery is covered.**

Your Homework:
- Contact your insurance company
  - **Verify that weight loss surgery is a covered benefit.**
    - Ask your insurance company if the following procedures are covered at the Medical University of South Carolina by your insurance plan:
      - Roux-en-Y Gastric Bypass (CPT 43644)
      - Sleeve Gastrectomy (CPT 43775)
      - Biliopancreatic Diversion with Duodenal Switch (CPT 43845)
      - Lap Band Removal (CPT 43774)
  - Ask about criteria required by your insurance company for surgery approval
    - ‘Medically supervised’ weight loss attempts (how many months?)
    - Letters of medical necessity
    - Surgical clearances required (like pulmonary, cardiac)
- **Please understand it is your responsibility to obtain the necessary paperwork required by my insurance company.**
- Complete the patient information packet and mail, fax or scan and email it to the MUSC Bariatric Surgery Program office including:
  - Patient Information Form
  - Initial Patient Nutrition Assessment Form
  - New Patient Questionnaire (medical history)
  - Bariatric Surgery Program Contract
- **Fax or mail in any paperwork from Primary Care Provider (PCP) to the MUSC Bariatric Surgery Program Office (fax: 843-876-4201)**
  - Results of heart, lung or stress test
  - Letter from PCP stating medical necessity
  - Records from PCP showing recent weight loss attempts
  - You may need to work with your PCP for 3-6 months to document ‘medically supervised weight loss attempts’ (Ask your insurance company if they have a specific form they require. We have included a sample for you).

Your Appointments
- Schedule an **initial patient consultation** with the surgeon to be evaluated
  - You will be contacted to make this appointment once we receive your packet
Checklist to Prepare for Weight Loss Surgery (Keep this page for your records)

Your Appointments
- Complete your initial nutrition assessment with one of our program dietitians
- Schedule and complete your psychosocial evaluation by the Behavioral Medicine clinic/team at the Institute of Psychiatry at MUSC, 67 President Street.
  - A referral will be sent on your behalf, but you must call to make your appointment 843-792-9162
  - We are allotted a limited number of appointment spots, so it is very important to keep your appointment or call them to reschedule as soon as you can.
- Attend the mandatory preoperative education class prior to surgery.
  - Class is held every 1st and 3rd Tuesday of the month from 12:30-3:00 PM in the Ashley River Tower Auditorium (you do not need to register, just show up, and we will document attendance).
- Acquire insurance approval (MUSC will compile your records and submit to your insurance company for the initial approval, which may take up to 30 days).
  - If you are denied, it is your responsibility to submit paperwork required for the appeal process.
  - If this happens, we are happy to guide you through this process
- Schedule your surgery date
  - You will be contacted when approval is received
- Complete a pre-operative clinic visit and meet with anesthesia
  - You will be contacted to schedule this when approval is received
  - A physician and/or PA who will obtain your medical history and perform a complete physical exam.
  - All deposits/co-pays must be paid at this visit.
- Surgery day!
  - You will be admitted to the hospital the morning of your surgery (you will know the date before, but you will find out the time about 2-3 days prior).
  - The scheduling office will call you between 2-4 pm the day prior to surgery. If you have not received a phone call by 4 pm, call the scheduling office at 843-876-5276.
  - You will be in the hospital for approximately 2 days.
  - You must have prior arrangements for transportation home from the hospital and an adequate care-giving plan for your first days at home.
- Follow up for LIFE
  - Because this is a PROGRAM and not just a procedure, we expect to have a lifelong relationship with you and we look forward to working with you and watching your progress with your weight loss.
  - Compliance to a follow-up schedule is critical to a successful outcome.
• **Verify Insurance Coverage**
  o Before you consider weight loss surgery, YOU MUST contact your insurance company to verify that weight loss surgery is covered by your policy and that MUSC is recognized as a provider by your insurance company. Some policies exclude all types of weight loss surgery. If there is no specific exclusion, a representative of the insurance company is generally contacted to verify whether the benefit is actually available.
  o One important point to keep in mind is that obesity and *morbid* obesity are considered two different health conditions. Many plans will exclude treatment for obesity but will cover treatment for *morbid* obesity.
  o Another important point to keep in mind is that not all representatives of a particular insurance company will be as knowledgeable about their policies as others. Some will not even know what morbid obesity is and you may be misinformed about coverage. It is important to check more than one source to verify that what you have been told is valid.

• **Benefit Guidelines**
  o Many insurance companies have their own specific benefit guidelines, describing whether treatment for morbid obesity will or will not be covered. If it is a covered benefit, they have specific requirements that must be met before they will authorize benefits for the treatment. The process can be long and difficult requiring much effort on the part of the patient and the doctor’s office.

The following is a basic list of what insurance companies may require in order to determine if treatment for morbid obesity is a covered benefit.

*Please note that we will not begin the pre-certification process until you have provided our office with all the required information:*

• **Documentation of Dieting**
  o Most insurance companies are asking for documentation of a physician directed weight loss program. We will need any and all medical records from your primary care provider. Most insurance companies that require adherence to a physician directed weight loss program are requiring documentation of at least 3-6 months. This may include monthly documentation from your physician. Verify with your insurance company the specific requirements.

• **Psychological Evaluation**
  o Insurance companies require a psychological evaluation. You will receive a comprehensive evaluation to assist in the identification of psychosocial strengths and weaknesses that may potentially affect bariatric surgery outcomes. You will be evaluated by our team of clinical psychologists before having surgery. If you are currently under the care of a counselor, psychiatrist, or psychologist, we ask that you obtain a letter of support from them.

• **Medical Records**
  o Medical records are required and must be submitted with all other documentation prior to the insurance company making a determination and approval for your surgery. Please provide us with your primary care provider’s medical records for the last five years. This will help us to document your ongoing problem with morbid obesity, as well as documentation of all treatments and interventions required for co-morbidities (i.e. diabetes, hypertension, etc).
Insurance and Financial Information (Keep this page for your records)

- **Letter of Medical Necessity**
  - This is a letter usually written by your surgeon that outlines your medical, diet and exercise history and your current state of health. It is the summary of all your information that makes the case for why surgical treatment for your morbid obesity is medically necessary. This letter is usually submitted with all your other documentation.
  - Some insurance companies also require a letter of medical necessity from your primary care provider as well. It is important that you verify with your insurance company what they require for approval of surgery.

- **Predetermination**
  - Once all your records are gathered and sent to the insurance company with the letter of medical necessity, the insurance company goes through a review process to determine if they will approve this benefit for you. At this point they may ask for more documentation, approve this benefit for you or deny this benefit to you. If you are denied, most insurance companies have up to 3 appeals that they allow you to make.
  - Make sure all documentation is complete prior to filing an appeal. It is also important not to be discouraged during the appeals process as many initial denial decisions are overturned in later appeals. It is your responsibility to make the appeals. We are happy to help guide you through this process.

- **Pre-certification**
  - If your benefits for treatment have been approved, a final process of pre-certification through the insurance company is made, and a final surgery date and pre-operative work up are scheduled and all financial matters are settled. Pre-certification generally must take place within 90 days of predetermination to be valid.

- **Copay and Coinsurance**
  - Bariatric surgery is covered by many insurance policies, and the amount that it costs depends upon the type of policy and its terms, as well as any contract arrangement with the hospital. If you wish to come to us for evaluation and surgery, we perform the insurance authorization and approval process without charge. With specific policy information and approval, we can obtain your out-of-pocket expected costs before surgery is scheduled.
  - University Medical Associates (UMA), the physician billing office, requires payment of your copay and coinsurance 14 days before surgery is performed. UMA will call and state the estimated coinsurance amount to be paid. We must, however, wait for such approval or have the financial commitment of the patient, prior to scheduling surgery.
  - All copayment, deductibles, and coinsurance must be paid in full prior to surgery. The financial counselor will provide you with the specific amount that is your responsibility. If you do not pay this prior to surgery – your surgery will be rescheduled.

- **No Insurance Coverage?**
  - Many patients choose to pay for the operation themselves. In cooperation with MUSC, we offer a special package for cash paying patients, which include all usual services, at a fixed fee. This fee must be paid in full prior to surgery or your surgery will be cancelled. The fixed fee is all that you will be required to pay for your hospitalization for the actual surgery – it is determined based on our expected costs. This fixed fee does not cover the costs of any pre-operative work up charges, or post-operative follow up care. If you have questions or would like a quote on the fixed fees – please call the financial counselor at 843-876-4864.
To Our Patients with Insurance requiring ‘Medically Supervised Diet or Weight Loss Attempt’

Many insurance companies are now requiring documentation in the medical record of between 3-6 consecutive months of weight loss attempts or a diet, monitored by a physician, during the 18 months immediately prior to the surgery.

What does this mean for you?

- You will have to prove 3-6 consecutive months (depending on insurance) of physician supervised weight loss attempts within the last 18 months.
- Proof consists of documentation of at least 3-6 consecutive monthly office visits regarding your weight loss attempts by a medical doctor or documentation that you participated in a medically supervised weight loss program (i.e.: MUSC Weight Management Center or the Metabolic Medical Center). If you have participated in a program like Weight Watchers, South Beach, Atkins, or Optifast, you will still need your doctor’s notes.

We have enclosed a sample of a monthly consecutive weight loss attempts form for your provider to complete each month. Please share this letter and form with your primary care physician. You may also ask your insurance company if they have a specific form or format that they require.

Visits must be ONE per month, 30 days apart, for a period of 3-6 consecutive months. No breaks between visits.

The following information MUST be documented in the office visit notes, each time you see your provider:

- Date of each office visit
- Current height and weight
- Diet/eating plan
- Exercise plan/prescription
- Behavior Modification plan
- Progress made between visits
- Other Comments/medical info that is pertinent

Sincerely,

Karl Byrne, MD
Rana Pullatt, MD
Aaron Lesher, MD
Monthly Consecutive Weight Loss Attempts for Patients Preparing for Bariatric Surgery

*This is an example of a form that includes the documentation that many insurance companies want when they require 3-6 months of ‘medically supervised weight loss’. SHARE THIS DOCUMENT WITH YOUR PRIMARY CARE PROVIDER; Fax completed forms to Lisa Steinbronn at 843-876-4201. Call 843-876-3046

Patient is being evaluated by MUSC for gastric bypass or vertical sleeve gastrectomy (circle one)
Insurance: ____________________________ Number of months of ‘medically supervised diet’ required: ______

Month (please circle) 1 2 3 4 5 6 Visit Date: ___/___/____

Patient’s Name: ______________________________ DOB: ___/___/____

Height (in): ______  Weight (pounds):________  Body Mass Index (kg/m²): __________

Blood Pressure: _____  Pulse: _____  Pertinent Medications: ______________________________________

Pertinent Comorbid Conditions/Diagnoses:
Please circle from most common: Diabetes, Hypertension, Gastrointestinal Reflux, Sleep Apnea, Asthma
Other: __________________   __________________   __________________   __________________

Treatment Recommendations: Please indicate what type of diet plan you have recommended

- Calorie-level diet: ________ total calories per day or restriction of ________ calories/day
- Macronutrient diet: □ low carbohydrate □ low fat □ high protein (Atkins, South Beach)
- Structured Programs: □ Weight Watchers □ Metabolic Medical Center/Physicians Plan
- Meal Replacements: □ Optifast/Medifast □ Slim Fast □ Jenny Craig □ Nutrisystem
- Medications: □ OTC (Alli) □ Phentermines (___mg/d) □ Orlistat/Xenical (___ mg/d)
- Belviq (___ mg/d) □ Qsymia (___ mg/d) □ Other: ____________________________________________

Exercise Prescription: Please indicate what type of exercise regimen you have recommended

- Type: □ Walking □ Swimming □ Aerobics □ Bike □ Resistance training □ Going to a Gym
- Program (Curves, Ladies Choice) □ Other: ________________________________________________
- Duration: ________ minutes  □ Frequency: ________ days/week

Response to prescribed regimen in past month: □ Lost ______ pounds □ Gained ______ pounds

Goals for next visit: □ lose ______ pounds □ adhere to diet plan □ adhere to exercise regimen

Comments: ___________________________________________________________ FOLLOW UP: Return in 1 month

Provider Signature __________________________________ Provider Name ____________________________ Date ____________________________
Bariatric Surgery Program
Initial Patient Application

Page 3 of 7

Form Origination Date: 5/2016
Version: 1
Version Date: (5/2016)

Patient Name _____________________________
MRN _____________________________

MUSC Bariatric Surgery Program Patient Information Form
(Complete & Return)

Name _____________________________
Birth date ___/____/____
Sex____
Marital Status____

SS#__________________________
Address__________________________
City ____________________________
County ____________________________
State____
Zip__________________________

Home Phone ____________________
Work Phone _____________________
Cell Phone ______________________

Ethnicity____________________
Email address__________________

Occupation____________________
Employer’s Name & Address____________________

Primary Care Provider (PCP) ______________________
Address of PCP ______________________
PCP phone ______________________

Referring Physician ______________________
Address of Referring Physician ______________________
Referring phone ______________________

Emergency Contact Name ______________________
Relationship ______________________
Address ______________________
City ______________________
State____
Zip____________________

Home Phone ____________________
Work Phone _____________________
Cell Phone ______________________

Insurance Information:
(Give as much information from your card, and enclose a copy if possible)

Name of Primary Insurance ______________________
Address ______________________
Customer Service Phone # ______________________
Prior Authorization Phone # ______________________
Policy or ID # ______________________
Group or Plan# ______________________
Subscribers Name on Card ______________________
Relationship to Patient ______________________
Subscribers Employer ______________________

Name of Secondary Insurance ______________________
Address ______________________
Customer Service Phone # ______________________
Prior Authorization Phone # ______________________
Policy or ID # ______________________
Group or Plan# ______________________
Subscribers Name on Card ______________________
Relationship to Patient ______________________
Subscribers Employer ______________________

How did you hear about us?

☐ MUSCHealth Website ☐ Internet – other ☐ Radio ☐ Newspaper ☐ Magazine
☐ Television ☐ Physician: Name: ______________________
☐ Friend: Name: ______________________

Indicate the Procedure you are interested in:

☐ Gastric Bypass ☐ Sleeve Gastrectomy ☐ Other: ______________________

Date you viewed online information video _________ or Attended Open House Live

Can the patient read or write? ☐ Yes ☐ No

Form completed by: ☐ Patient ☐ Other:
MUSC Bariatric Surgery Program Contract (Complete & Return)

Please read each statement carefully and initial in the corresponding space to indicate that you have read, understand, and agree with this contract. We believe this demonstrates your commitment to your health and adherence to the requirements of the Medical University of South Carolina (MUSC) bariatric surgery program.

Initials

1. The goals, risks and benefits and alternatives of Roux-en-Y Gastric Bypass Surgery (RYGB), Sleeve Gastrectomy, and/or Biliopancreatic Diversion with Duodenal Switch Surgery were explained to me and I have [ ] attended the risks and benefits lecture or [ ] viewed online at http://www.muschealth.org/weight-loss-surgery/

2. Any medical condition that exists or may develop, not in direct relationship to bariatric surgery, must be treated by my primary care physician, and I agree to coordinate my care with my surgeon. I understand that my surgeon cannot treat me or fill prescriptions for non-surgical medical problems.

3. I understand that insurance pre-authorization can take from 30-60 days or longer.

4. I understand, based on my insurance, there may be a deposit or co-pay required. I understand that it is the policy of MUSC to collect any deposits or co-payments at the time of service.

5. I understand that if I am denied coverage by my insurance company, I am responsible for payment of all services rendered, to include all pre-surgery screenings, counseling, lab work, etc.

6. I understand any portion of the fees for which I am responsible must be paid prior to my operation.

7. The decision to have weight loss surgery is made by my own free will. I have not been coerced into making this decision by my surgeon or any other individual or family member.

8. I understand that my evaluation as a surgical candidate will be by a multidisciplinary team. Based on the findings, a decision will be made on whether or not I am an appropriate candidate for surgery. I understand that certain findings may indicate I am not an appropriate candidate for surgery.

9. I understand the importance of maintaining follow up with my surgeon/team and agree to maintain follow up annually for the rest of my life.

10. I understand that successful long-term weight maintenance is based on the principles and guidelines of the surgical weight loss program.

11. I understand that I am required to take vitamins for life after having bariatric surgery.

12. I understand that I am required to attend a mandatory preoperative nutrition class prior to surgery and am encouraged to attend postoperative classes and support group.

13. I agree to return in a timely fashion for routine office visits, which are an important part of the long-term follow-up after weight loss surgery. I understand there may be additional fees for these visits.

14. I have read and understand this document.

Signature: ___________________________ Date: ___________________________

Print Name: ___________________________
MUSC Bariatric Surgery Program Nutrition Assessment Form (Complete & Return)

Height (inches):_________ Weight (pounds):_________ Email Address:_______________

**Eating Habits/Diet History**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long have you been thinking about having weight loss surgery?</td>
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<tr>
<td>What made you decide at this time to pursue surgery?</td>
<td></td>
</tr>
<tr>
<td>What was your best weight loss in your life? How did you lose weight?</td>
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<tr>
<td>About what year?</td>
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<tr>
<td>What seems to be the best way you are able to lose weight?</td>
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<tr>
<td>From what age have you struggled with your weight?</td>
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</tr>
<tr>
<td>What were your maximum and minimum adult weights?</td>
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<tr>
<td>Are you taking any dietary/herbal supplements or vitamins/minerals?</td>
<td></td>
</tr>
</tbody>
</table>

**Previous Attempts at Weight Loss Efforts (Past 5 Years only)**

List Structured Programs (like Weight Watchers, Metabolic Medical Center), Diets (like Atkins, South Beach), Prescription Medications (like Phentermines, Orlistat, Belviq), Over the Counter medications (like Alli, Metabolife), physician or dietitian supervised weight loss attempts, other weight loss surgery, and any others.

<table>
<thead>
<tr>
<th>Name of Program, Diet, Medication, Surgery etc.</th>
<th>Date/year you started</th>
<th>How long on it (days, weeks, months, years)</th>
<th>How many pounds did you lose</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Exercise/Physical Activity Habits (Complete & Return)

<table>
<thead>
<tr>
<th>Do you exercise/get physical activity?</th>
<th>Type (walking, gym, biking, swimming, exercise classes, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency/Times per week:</td>
<td>Time/Minutes per session:</td>
</tr>
</tbody>
</table>

Eating Habits

In general, how many eating occasions (meals/snacks) do you typically have each day? _____ meals _____ snacks

What time of day do you eat meals and snacks?

What do you do for work?

What are your typical work hours?

Who else lives in the home with you?

Do other family members struggle with their weight?

Who does the food shopping and preparation?

Do you plan meals in advance? Do you shop from a list?

Where do you typically eat your meals (table, couch, bed, kitchen)?

Do you have any food allergies or intolerances?

Food Habits Inventory:
To get a sense of how often you eat certain foods, please select how often do you eat foods from the following food groups: number of times per day, week, or per month, and which foods you tend to eat from each group.

<table>
<thead>
<tr>
<th>Food Group/Type</th>
<th>How often</th>
<th>Which foods</th>
</tr>
</thead>
</table>
| **Protein-rich foods:** like beef, pork, ham, sausage, bacon, venison, chicken, turkey, lunch meats, tunafish, fish, seafood, eggs, beans, nuts, plant based proteins like tofu, veggie burgers (and any others) | # of times eaten:  
__ daily  
__ wk  
__ month | Which types, and how do you prepare? |
| **Dairy:** Milk, yogurt, cottage cheese, cheese | # of times eaten:  
__ daily  
__ wk  
__ month | Which types? |
### Food Habits Inventory (continued):

<table>
<thead>
<tr>
<th>Category</th>
<th># of times eaten:</th>
<th>Which types, and how do you prepare?</th>
</tr>
</thead>
</table>
| **Vegetables**: cooked, raw, or salads | ___ daily  
___ wk  
___ month |                                      |
| **Fruits**: fresh, canned, frozen | ___ daily  
___ wk  
___ month |                                      |
| **Starches**: bread, rice, pasta, potatoes, bagels, cereals, grits | ___ daily  
___ wk  
___ month | Which types? |
| **Added fats**: oil, butter, fried foods | ___ daily  
___ wk  
___ month | Which types? |
| **Snacks**: Salty snacks (chips, fritos, popcorn, pretzels, goldfish, crackers, nabs), nuts | ___ daily  
___ wk  
___ month | Which do you tend to go for? |
| **Sweets**: chocolate, icecream, cake, cookies, candy, include sugar free versions | ___ daily  
___ wk  
___ month | Which do you tend to go for? |
**Food Habits Inventory (continued):**

<table>
<thead>
<tr>
<th>Eating Out: Meals outside of home: sit down, eat out, take out, delivery</th>
<th># of times eaten:</th>
<th>Where do you tend to go out to eat, and what do you get?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___ daily</td>
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<tr>
<td></td>
<td>___ wk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ month</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beverages: soda (reg/diet), sweet tea, kool aid, juice, milk, coffee, energy drinks</th>
<th># of times drank:</th>
<th>Which beverages do you drink and how much (in ounces or number of bottles/cans)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___ daily</td>
<td></td>
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<tr>
<td></td>
<td>___ wk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ month</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol: beer, wine, hard liquor, mixers</th>
<th># of times drank:</th>
<th>Which alcohol types, and how much per occasion?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___ daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ wk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ month</td>
<td></td>
</tr>
</tbody>
</table>

**Discussion about Weight Loss Surgery**

<table>
<thead>
<tr>
<th>Which type of weight loss surgery are you interested in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much weight do you hope to lose with surgery?</td>
</tr>
<tr>
<td>In what time frame do you expect to lose this weight?</td>
</tr>
<tr>
<td>Do you have any non-scale goals or things you are looking forward to with weight loss?</td>
</tr>
</tbody>
</table>

**Next Steps**

Before you undergo surgery, you are required to attend the MANDATORY preoperative education class where you will be educated verbally and with written educational materials about the nutritional recommendations for post-surgery eating, supplements, and behaviors. **Preoperative class is the 1st and 3rd Tuesday of EVERY month from 12:30-3:00 PM in the Ashley River Tower Auditorium.**

What would you say your biggest challenges will be with changing your eating habits?
New Patient Questionnaire
To be Completed by Patient
Page 1 of 4

Form completed by □ Patient □ 

PRIMARY CARE and REFERRING PHYSICIAN(S)

Physician Name
Address
Phone

CURRENT MEDICAL PROBLEM
What problem brought you here?
What symptoms are you having?
When did your symptoms start?

Has your appetite changed in the last six months? □ Decreased □ Increased □ Stayed the same
Current Height ___________ Weight ___________ lbs
Has your weight changed in the last six months? □ No □ Yes If yes, gained _____ lbs lost _____ lbs
Has your overall energy / pep level changed? □ Decreased □ Increased □ Stayed the same

PAST MEDICAL / SURGICAL HISTORY
Have you had any difficulty with anesthesia in the past? □ No □ Yes, explain:
Have you had any problems with bleeding during or after surgery in the past? □ No □ Yes, explain:

Please list any medical problems (e.g., diabetes, high blood pressure, cancer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>5.</td>
</tr>
<tr>
<td>2.</td>
<td>6.</td>
</tr>
<tr>
<td>3.</td>
<td>7.</td>
</tr>
<tr>
<td>4.</td>
<td>8.</td>
</tr>
</tbody>
</table>

Females:
- Number of times you have been pregnant:
- Number of miscarriages:
- Age when you started your period:
- Hormone replacement: □ No □ Yes, number of years:

Number of live births:
Number of abortions:
Age at menopause:

Please list any previous operations or procedures

<table>
<thead>
<tr>
<th>Procedure or Operation</th>
<th>Date</th>
<th>Surgeon(s)</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Reviewing RN Signature ___________________________ Date/Time ___________________________

newptquestionnaire
FAMILY HISTORY

Are there any diseases that run in your family?

<table>
<thead>
<tr>
<th>Disease</th>
<th>Family member affected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

MEDICATIONS

In the boxes below, please list all medications or pills that you take, whether or not prescribed by a physician. Record them just as they are on the drug bottle / box. Please include all vitamins, herbal supplements, and/or over-the-counter medications.

<table>
<thead>
<tr>
<th>Medicine or pill name</th>
<th>Dose (e.g., 50 mg)</th>
<th>How many times per day?</th>
<th>Why do you take this?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Please list any allergies.

<table>
<thead>
<tr>
<th>Name</th>
<th>What happens if taken or eaten?</th>
<th>Name</th>
<th>What happens if taken or eaten?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

Are you allergic to shellfish? □ No □ Don’t Know □ Yes

Have you had an allergic reaction to contrast or dye injected in a medical test? □ No □ Don’t Know

□ Yes, what happened? □ Rash □ Short of breath □ Other ____________________________

VACCINATIONS

Have you received a pneumonia vaccine within the past 5 years? □ No □ Don’t Know □ Yes, date: ______

Have you received a flu vaccine this flu season? □ No □ Don’t Know □ Yes, date: ______
SOCIAL HISTORY

☐ Single  ☐ Married  ☐ Separated / Divorced  ☐ Widowed

What is your current or former occupation?

Do you currently or have you ever used tobacco?  ☐ Never  ☐ No / Quit  ☐ Yes  ☐ I would like to quit.

If yes or quit, how much per day? ______  Age you started: _____  Age you quit: _____

Type:  ☐ Pipe  ☐ Cigars  ☐ Smokeless Tobacco
☐ Cigarettes, have you smoked this past year?  ☐ No  ☐ Yes

Do you or have you used alcohol?  ☐ Never  ☐ No / Quit  ☐ Yes

If yes or quit, how much per day? __________

Type:  ☐ Beer  ☐ Wine  ☐ Hard Liquor  ☐ Moonshine

Do you or have you used recreational drugs?  ☐ Never  ☐ No / Quit  ☐ Yes, type: ________________

Prior to this illness, did you have any problems taking care of your daily activities of living (e.g., bathing, walking)?

☐ No (Independent)  ☐ Need some help / assistance  ☐ Need constant help (Dependent)

Do you currently have any problems taking care of your daily activities of living (e.g., bathing, walking)?

☐ No (Independent)  ☐ Need some help / assistance  ☐ Need constant help (Dependent)

Do you have difficulty falling asleep or staying asleep at night?  ☐ No  ☐ Falling asleep  ☐ Staying asleep

Are you bothered by unpleasant sensations in your legs in the evening or in bed (such as tingling, “creepy crawlly” feelings) that get better when you move your legs or get up and walk?  ☐ No  ☐ Yes

If you have a bed partner, does he / she report that you kick or move your legs excessively during your sleep?

☐ No  ☐ Yes  ☐ I sleep alone

Do you have an advance directive (living will, durable power of attorney)?  ☐ No  ☐ Yes, please provide copy.

Do you have any religious or cultural beliefs that you would like your doctor to know about?  ☐ No  ☐ Yes

If yes, explain: ____________________________________________________________

How do you learn best?  ☐ Pictures  ☐ Books / pamphlets  ☐ Video  ☐ Talking to others  ☐ Computer

Do you have problems with transportation?  ☐ No  ☐ Yes

Do you have financial concerns?  ☐ No  ☐ Yes

EMERGENCY CONTACT INFORMATION

Name ___________________________________________ Phone __________________

Name ___________________________________________ Phone __________________

Reviewing RN Signature ___________________________________________ Date/Time __________________

newptquestionnaire
### Do you currently have or have you had any of the following?

#### CONSTITUTIONAL

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How bad is your pain? (circle one):  
0  1  2  3  4  5  6  7  8  9  10  
(no pain..........................worst pain ever)

Type of pain (check all that apply):  
- Burning
- Stabbing
- Tingling
- Dull
- Throbbing
- Radiating
- Cramping
- Intermittent

#### EYES / EARS / NOSE / THROAT

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blurred or double vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard of hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose bleeds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### CARDIOVASCULAR

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain / angina</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you been treated for this in the past 30 days?  
- No
- Yes

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular heart beat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankles / feet swelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you been treated for this in the past 30 days?  
- No
- Yes

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart attack or myocardial infarct (MI)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Have you been treated for this in the past 6 months?  
- No
- Yes

#### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm numbness / weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg numbness / weakness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### GASTROINTESTINAL

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea / vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody stool or black stool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in bowel habits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NEUROLOGY

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, did you have any problems afterwards?  
- No
- Yes

Explain:  
“Mini stroke” or TIA  
- No
- Yes, date:

Seizure  
- No
- Yes, date:

#### GENITOURINARY

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Painful urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### IMMUNE SYSTEM / NUTRITIONAL / Misc

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type(s):  
- Has it spread to other locations?  
- No
- Yes

If yes, where:  

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you had any in the past 30 days?  
- No
- Yes

Radiation  
- No
- Yes

Have you had any in the past 90 days?  
- No
- Yes

#### OTHER

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open wounds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**AUTHRELEASE**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

<table>
<thead>
<tr>
<th>Check ONE box</th>
<th>Release Records To:</th>
<th>(Where do you want the information sent? Who may have the information?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>OR Obtain Records From:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Who has the information you want released?) Please list the specific</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital and /or clinic.</td>
</tr>
</tbody>
</table>

**NAME/ ORGANIZATION:** MUSC Bariatric Surgery Program  
**Attention to:** Lisa Steinbronn

**Address:** 25 Courtenay Drive, MSC 290

**City:** Charleston  
**State:** SC  
**Zip code:** 29425

**Day Phone Number:** 843-876-4264  
**Fax Number:** 843-876-4201

**Release Instructions:**

(How do you want the information?)  
**Release Method / Format requested:** (check one)

- [ ] Mail  
- [ ] DVD/CD  
- [X] My Chart/Epic  
- [ ] Fax (To healthcare provider ONLY)  
- [ ] Other

**Purpose of Release:**

(Why is it needed?)  
- [X] Continuing Care  
- [ ] Legal  
- [ ] Patient Request  
- [ ] Military  
- [X] Insurance  
- [ ] Disability  
- [ ] School  
- [ ] Other

I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.

**Treatment Date(s):**

(When were you seen?)  
- [ ] Treatment dates from to (Please be specific)  
- [X] All Treatment Dates

**Information to be Released:**

(What do you want sent or released? Check the appropriate boxes.)  
- [X] ENTIRE RECORD  
- [ ] Images/DVD  
- [ ] Immunization records  
- [ ] Medication list  
- [ ] Physician progress/ visit notes  
- [ ] Abstract Information  
- [ ] History & Physical, consults, lab & radiology reports, discharge summary, operative/procedure reports, Emergency Department reports, and Occupational / Physical Therapy reports.  
- [ ] Psychotherapy  
- [ ] Other:

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date or .

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization. (NOTE: STATE LAW ALLOWS 45 DAYS for Processing.)

**Printed Name of Patient or Legal Guardian / Representative**

**Date**

**Signature of Patient or Legal Guardian/Representative**

**Relationship to Patient, if signed by Legal Guardian**

**Witness Signature**

**Document(s) of patient representative’s authority must be attached if patient is not signing.**

To contact Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 /Suite 200/ Attn: Release of Information / Charleston, South Carolina 29425; the phone number is (843) 792-3881. Fax number is (843) 876-8080 or (843) 876-8055.

Original to Health Information Services (medical records department)  
Copy to patient

OTE 700078 Rev. 12/15