

Patient Name: _____ Date of Birth: _____
(Last) (First)



NORTON
WEIGHT MANAGEMENT
SERVICES

NORTON
HEALTHCARE

BARIATRIC SURGERY
PATIENT PACKET

Patient Name: _____ Date of Birth: _____
(Last) (First)

Welcome to Norton Weight Management Services. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are many steps leading up to bariatric surgery, so we have developed a multidisciplinary team to help you. It is very important that you take an active role during this process. Your effort will ensure the process moves as efficiently as possible.

In order to provide you with the best possible service, we must have the following information on file before scheduling your appointment in the Bariatric Center. You may use this sheet as a checklist for your items.

The Bariatric Center Patient Packet: Complete all forms and provide all necessary information to take the next steps in the program.

Insurance cards: Include copies of **any/all** insurance cards, front and back.

Medical Records: Ask your doctor for the last 12 months of your medical records. These are the notes in your chart that the doctor makes during your visit. Ask your doctor for copies of your medical records that support your history of obesity and any diseases you have been treated for related to obesity.

Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved. This means you will need to see your doctor every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers®, Jenny Craig®, etc) many times do not meet this requirement.

Physician letters of support: Ask your primary care physician or any other physicians you have seen, such as cardiologists, pulmonologists, orthopaedic specialists, obstetricians/gynecologists, to write a letter of support. (See sample letter attached.)

Personal letter: If you choose, you may provide a personal letter explaining your medical condition and how your weight affects your life physically, mentally, financially, spiritually, etc.

Please bring the completed packet, copies of your insurance cards, medical records and letters with you when you attend an information seminar, or mail the information to the address below. If you have any questions, call the Bariatric Center at (502) 899-6500.

We look forward to assisting you.

Send completed information to:
Norton Weight Management Center
1000 Dupont Rd.
Louisville, KY 40207
Telephone: (502) 899-6500
FAX: (502) 895-2675

Patient Name: _____ Date of Birth: _____
(Last) (First)

TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____ SUFFIX _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NO.: _____

RACE: (For Multi-racial choose all that apply)

- African American Caucasian Native American or Alaska Native Other
 Asian Hispanic Native Hawaiian or Other Pacific Islander

GENDER: Male Female

Marital Status: [] SINGLE [] MARRIED [] WIDOWED [] DIVORCED

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ WORK #: * _____ EXT: _____

CELL #: _____ FAX #: _____ E-MAIL: _____

* MAY WE CONTACT YOU AT YOUR WORK NUMBER? _____

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS:

- Full Time Part Time Self Employed Homemaker Student Retired
 Disabled – if yes, please provide reason for disability _____ Unemployed

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE INFORMATION

NAME: _____ DOB: _____

EMPLOYER: _____ EMPLOYER PHONE NO.: _____

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NO.: _____ ADDRESS: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NO.: _____ ADDRESS: _____

Patient Name: _____ Date of Birth: _____
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INSURANCE INFORMATION

PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH FRONT & BACK, WHEN SUBMITTING THIS FORM

Disclaimer:

- Norton Weight Management Services is not responsible for incorrect information that 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 also 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 a bariatric surgeon.

PLEASE PRINT CLEARLY

Fill in this information.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	
Provider Telephone Numbers (listed on back of card)	

Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved. This means you will need to see your doctor every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) do not meet this requirement.

We will verify if your policy includes a medically supervised weight loss requirement and communicate this information to you. You may call the customer service number listed on your card to determine if you need this, and begin seeing your doctor every month for six months to help speed the process along. *We do recommend that you contact the customer service number on your card in order to better understand the benefits specific to your insurance policy. Submission for approval for surgery does not occur until after the surgeon consult, and all required information is submitted to the insurance company.*

Some insurance policies have contract exclusions which mean that weight loss 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 that it is not covered in your contract and they will not pay for it. Cash pay information is available by request.

If you have questions regarding your insurance, please contact the Bariatric Center at (502) 899-6500.

Patient Name: _____ Date of Birth: _____
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PLEASE CHECK BELOW IF YOU HAVE A HOSPITAL/SURGEON PREFERENCE

- | | |
|---|---|
| <input type="checkbox"/> NORTON HOSPITAL | <input type="checkbox"/> NORTON SUBURBAN HOSPITAL |
| <input type="checkbox"/> GERALD M. LARSON, M.D. | <input type="checkbox"/> JEFFREY W. ALLEN, M.D.* |
| <input type="checkbox"/> FARID KEHDY, M.D. | <input type="checkbox"/> DAVID GELLER, M.D.* |
| <input type="checkbox"/> JORGE RODRIGUEZ, M.D.* | <input type="checkbox"/> MARK SHINA, M.D.* |
| | <input type="checkbox"/> BEN TANNER, M.D.* |

***Medicare patients must choose a physician designated by this asterisk**

- NO HOSPITAL OR SURGEON PREFERENCE/FIRST AVAILABLE

IF YOU MARKED A SURGEON, PLEASE TELL US WHY:

- Physician Referral Word of Mouth Website
 Other _____

PLEASE CHECK THE SURGERY IN WHICH YOU ARE INTERESTED

- ROUX-en-Y GASTRIC BYPASS
 LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING

DO YOU REQUIRE ANY DEVICE OR ASSISTANCE WITH AMBULATION

- NO
 CANE WALKER WHEELCHAIR SCOOTER

DO YOU HAVE ANY COMMUNICATION CONCERNS WE SHOULD BE AWARE OF

- ENGLISH AS A SECOND LANGUAGE
 DIFFICULTY HEARING
 OTHER _____

Patient Name: _____ Date of Birth: _____
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BARIATRIC PROGRAM FEE AND ADDITIONAL FEES

You will be required to pay a **one-time, non-refundable Program Fee of \$300.00 to Norton Healthcare. The program fee is not billed to insurance.** The \$300.00 fee covers

- review of your medical history by professionals in the Bariatric Center
- verification of your benefits regarding weight loss surgery
- your initial assessment at the Bariatric Center (approximately a 2 hour visit, including individual consultation with a bariatric nurse, dietitian and mental health professional)
- educational materials
- life-time post procedure support from our team of nurses, dietitians and mental health professionals, including support groups and individual consultation

Payment will be due at the time of registration. You are responsible to obtain any REFERRAL from your primary care physician if you have an HMO and/or your insurance requires REFERRALS. Norton Healthcare will reschedule or cancel appointments pending payment of applicable fees and insurance. **This fee does not include any additional fees that may be charged when you see your surgeon.** This fee also does not guarantee insurance approval for your surgery through your surgeon's office.

SCHEDULING POLICY FOR NORTON HEALTHCARE BARIATRIC CENTER

To make the best use of your time and to meet the needs of all of our patients, we require that appointments be scheduled with our staff and we expect you to keep your appointments and to be on time. Failure to be on time could result in rescheduling of your appointment. We understand circumstances may require you to reschedule your appointment. Please contact our office at least 24 hours before your appointment to cancel and reschedule. Failure to cancel your appointment with 24 hours notice may result in rescheduling problems. If you cancel two appointments or do not show up for an appointment on two occasions without calling to reschedule, we reserve the right to refuse to schedule future appointments and to discontinue your participation in our program. Your cooperation in scheduling and keeping appointments will be greatly appreciated.

Please check and sign below.

I have read and understand the above statements related to the Bariatric Program Fee and the Scheduling Policy.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____
(Last) (First)

Norton Healthcare

Medical History for Bariatric Surgical Assessment

The questions asked on the following pages are very important. Please fill out the packet completely. The information you provide will be used by your surgeon's office to submit your case to insurance for approval of your surgery. Thank you.

Patient Name: _____ Date of Birth: _____
(Last) (First)

SAMPLE PHYSICIAN LETTER OF SUPPORT

Please obtain a letter of support from your primary care physician.

This form is a sample only and will not be accepted if the blanks are completed. Your physician must provide a separate letter of support.

Date

PHYSICIAN NAME
ADDRESS
CITY, STATE ZIP CODE

RE: PATIENT NAME
DATE OF BIRTH:

To Whom It May Concern:

The above named patient has been seen by our office for (____) years. (He/she) suffers from the following co-morbidities: (List any diseases related to obesity such as hypertension, diabetes, sleep apnea, degenerative joint disease, etc.) (His/her) current weight is (____ lbs), height: (____) and BMI: (____). The patient has undergone the following weight loss attempts: (List any previous attempt, including Weight Watchers, Jenny Craig, Nutri-system, Slim Fast, etc., or any therapies you have prescribed).

I feel this patient would benefit from weight loss surgery because (he/she) has been unsuccessful losing weight with other diet methods, and (his/her) medical conditions will become life threatening if (he/she) does not get (his/her) weight under control.

I appreciate your consideration. Please contact me for further questions.

Sincerely,

Physician Name

Patient Name: _____ Date of Birth: _____
 (Last) (First)

Physician Information	
Referring or Primary Care Physician Name:	Phone:
Address/City/State/Zip	FAX:

Please list any other physicians whose care you are under.

	Name	Address/City/State/Zip	Phone
Cardiologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Pulmonologist			
Therapist			
Other			

***Reminder:** If your insurance company requires **a six month physician supervised medical weight management program** before surgery is approved, your family physician can assist you with this. In order to complete this program, you will need to have **monthly** appointments with your physician, and a documented treatment plan in your medical records that includes height, weight and discussion/recommendations for diet and exercise plan. You must complete these monthly appointments continuously for the amount of time your insurance policy requires. Diet programs (Weight Watchers®, Jenny Craig®, etc) many times do not meet this requirement. *The Norton Weight Management Center can provide forms your physician can use to document these visits.*

.....

Patient Name: _____ Date of Birth: _____
 (Last) (First)

What is your current weight in pounds? _____ What is your current height? Feet: _____ Inches: _____

How many years have you been overweight? _____ Were you overweight as a child? _____

Is your weight mostly located in your: _____ Face _____ Abdomen _____ Hips
 _____ Arms/Legs _____ All

Please Check and Provide Information For All That Apply

Medically Supervised Diet Programs:

	# of Attempts	Date(s)	Length of Time	Weight Loss	Regained?
Medi-Fast	_____	_____	_____	_____	_____
Opti-Fast	_____	_____	_____	_____	_____
Fen/Phen	_____	_____	_____	_____	_____
Redu x	_____	_____	_____	_____	_____
Meridia	_____	_____	_____	_____	_____
Behavior Modification	_____	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____	_____
Dietitian Recommended	_____	_____	_____	_____	_____

Non-MD Supervised Program:

	# of Attempts	Date(s)	Length of Time	Weight Loss	Regained?
Weight Watchers	_____	_____	_____	_____	_____
Nutri-Systems	_____	_____	_____	_____	_____
Jenny Craig	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Liquid Diets:

	# of Attempts	Date(s)	Length of Time	Weight Loss	Regained?
Slimfast	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Miscellaneous Diets:

	# of Attempts	Date(s)	Length of Time	Weight Loss	Regained?
Low Calorie Diet	_____	_____	_____	_____	_____
Low Fat Diet	_____	_____	_____	_____	_____
High Protein Diet/Low Carb Diet: (Atkins, South Beach, Zone)	_____	_____	_____	_____	_____
Self Imposed Fasts	_____	_____	_____	_____	_____
Pritikin	_____	_____	_____	_____	_____
Richard Simmons	_____	_____	_____	_____	_____
Metabolife	_____	_____	_____	_____	_____
Herbal Life	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Please list ANY other attempts that you have made to lose weight that are not listed:

Patient Name: _____ Date of Birth: _____
 (Last) (First)

PREVIOUS WEIGHT LOSS SURGERIES?

If Yes, please provide the following information:

PROCEDURE	YEAR	SURGEON	HOSPITAL

PREVIOUS SURGERIES

- | | | |
|--|--|---|
| <input type="checkbox"/> Anti-reflux procedure | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast cancer, radiation |
| <input type="checkbox"/> Breast cancer, biopsy | <input type="checkbox"/> Breast cancer, mastectomy | <input type="checkbox"/> Bowel resection |
| <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Cesarean section | <input type="checkbox"/> Discectomy |
| <input type="checkbox"/> Gall bladder removal | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Nissen fundoplication |
| <input type="checkbox"/> Peripheral vascular procedure | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Vagotomy |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Other, not listed | |

If you checked any previous surgery above, please provide the following information:

PROCEDURE	YEAR	SURGEON	HOSPITAL

Did you have any complications with any previous surgery? (i.e., Blood Clots, Infections, Respiratory, Blood pressure problems) If so, please list:

ANESTHESIA HISTORY:

Have you ever had general anesthesia?..... Yes No

Have you ever had any problems with anesthesia?Yes No Explain_____

Patient Name: _____ Date of Birth: _____
 (Last) (First)

HEIGHT _____ WEIGHT _____

REVIEW OF SYMPTOMS

High Blood Pressure.....	Yes	No
Diabetes.....	Yes	No
Sleep Apnea.....	Yes	No
Have you had a sleep study done?	Yes	No
Sleep study done, no CPAP or BiPAP	Yes	No
Sleep apnea requiring CPAP or BiPAP	Yes	No
Sleep apnea, with CPAP or BiPAP and Oxygen	Yes	No
Arthritis.....	Yes	No
Reflux.....	Yes	No

HEART PROBLEMS:

Chest Pain.....	Yes	No
Difficulty breathing when you exert yourself.....	Yes	No
Do you lose your breath when you lie flat?.....	Yes	No
High Cholesterol.....	Yes	No
Heart Disease.....	Yes	No
Heart Murmur.....	Yes	No
Swelling in feet/hands and/or legs.....	Yes	No

RESPIRATORY PROBLEMS:

Shortness of breath.....	Yes	No
Emphysema/lung disease.....	Yes	No
Asthma.....	Yes	No
Chronic Obstructive Pulmonary Disease (COPD).....	Yes	No
Have you ever had pneumonia.....	Yes	No

Patient Name: _____ Date of Birth: _____
(Last) (First)

Have you ever coughed up blood..... Yes No

Do you have wheezing in your lungs..... Yes No

Have you ever had tuberculosis..... Yes No

GASTROINTESTINAL PROBLEMS:

Heartburn.....Yes No

Ulcers..... Yes No

Difficulty swallowing foods or liquids.....Yes No

Does it hurt to swallow.....Yes No

Nausea/vomiting..... Yes No

Have you ever vomited blood.....Yes No

Abdominal pain..... Yes No

Diarrhea.....Yes No

Constipation.....Yes No

Blood in stool.....Yes No

Dark black stools.....Yes No

Fatty Liver (NASH).....Yes No

Hepatitis.....Yes No

Cirrhosis.....Yes No

Have you ever turned yellow in color (jaundice).....Yes No

GENITOURINARY PROBLEMS:

Frequent kidney (urinary tract) infections.....Yes No

History of kidney stones..... Yes No

Have you ever urinated blood?.....Yes No

Difficulty holding your urine
(especially when sneezing or coughing).....Yes No

Patient Name: _____ Date of Birth: _____
(Last) (First)

BLOOD ISSUES:

Anemia.....Yes No
Bleeding disorder..... Yes No
Blood clots in legs or lungs..... Yes No

ENDOCRINE PROBLEMS:

Thyroid disease.....Yes No

NEUROLOGICAL/VISION/EAR/NOSE/THROAT PROBLEMS:

Seizures..... Yes No
Headaches..... Yes No
Vision Problems (other than having to wear glasses).....Yes No
Blindness in one or both eyes.....Yes No
Difficulty hearing what others say..... Yes No
Do you wear a hearing aid..... Yes No
Frequent nosebleeds..... Yes No

SKIN PROBLEMS:

Eczema.....Yes No
Skin Rashes.....Yes No
Any moles that have recently changed.....Yes No
Cellulitis.....Yes No
Abdominal Skin Irritation.....Yes No

MUSCULOSKELETAL PROBLEMS:

Back pain..... Yes No
Neck pain.....Yes No
Joint pain..... Yes No

Patient Name: _____ Date of Birth: _____
(Last) (First)

Pain in your arms or legs..... Yes No
Weakness in your arms or legs.....Yes No
Numbness in your arms or legs.....Yes No

MENTAL HEALTH

Have you ever been severely depressed.....Yes No
Have you ever been diagnosed with a psychosisYes No
Have you ever been hospitalized with an emotional problem.....Yes No
Have you ever attempted suicide.....Yes No

FOR FEMALES ONLY:

Do you have regular periods? (26-33 days).....Yes No
If no, please describe _____

Do you have excessively heavy periods.....Yes No

Could you be pregnant?..... Yes No
Last period _____

Do you take birth control pills?..... Yes No

Have you ever had difficulty getting pregnant?..... Yes No

Do you currently have problems with infertility..... Yes No

Have you suffered from excess body hair..... Yes No

Have you suffered from excess acne..... Yes No

Have you ever been told you have polycystic ovaries? Yes No

Number of pregnancies _____ Number of children _____ Miscarriages _____

Have you had any problems with pregnancy and/or childbirth... Yes No
If yes, please describe _____

Have you had a cesarean section? Yes No
If yes, why? _____

Is there a chance you may get pregnant in the future?..... Yes No

Patient Name: _____ Date of Birth: _____
 (Last) (First)

SOCIAL HISTORY

SMOKING HISTORY:

Have you ever smoked cigarettes?..... Yes No

Are you currently smoking?..... Yes No

If you are a smoker, how many years have you smoked? _____

Number of pack(s) per day _____

If you previously smoked, and have quit, how long have you been cigarette free? _____

ALCOHOL CONSUMPTION: YES / NO FREQUENCY: _____ HOWMUCH PER WK? _____

HISTORY OF SUBSTANCE ABUSE? YES / NO

(Alcohol, marijuana, cocaine, crack, iv drugs, etc.)

IF YES, GIVE DETAILS OF TREATMENT:

WHEN? _____ WHERE? _____

FAMILY HISTORY

	Mother	Father	Siblings (please indicate brother or sister)	Other Relatives (grandparents)
Morbid obesity				
High blood pressure				
Diabetes				
Heart disease				
Joint pain/disease				
Cancer				
If deceased, age of death/cause				

Patient Name: _____ Date of Birth: _____
(Last) (First)

Norton Healthcare

Nutrition-Related History **for Bariatric Surgical** **Assessment**

Patient Name: _____ Date of Birth: _____
(Last) (First)

Nutrition Related History:

Have you ever before had a "stomach stapling" procedure or other gastric surgery? _____

If yes, please describe the surgery: _____

What was your greatest single weight loss in pounds? _____

How did you lose the weight? _____

How long did you sustain that weight loss? _____

Are you currently under a Physician's care for weight loss? _____

Physician's Name: _____

Address/Phone: _____

Do you get any physical activity? _____ If yes, how much and what activity?

Do you eat three meals per day? _____ Do you snack between meals- if so, what do you snack on?

What are your favorite foods/foods you crave?

Do you eat large meals (gorge)? _____ Do you eat a lot of sweets? _____

Do you drink fluids regularly during the day? _____ What do you drink? _____

Do you drink soda pop? _____ Is it regular or diet? _____ How many/day? _____

Do you drink alcohol? _____ What do you drink? _____ How many/day? _____

How many/week? _____

Do you ever make yourself vomit after eating- how often? _____

If yes, when was the last time you made yourself vomit after eating? _____

Do you have any restrictions on your current diet? If so, what is restricted and why?

How often do you eat out per week? _____ How often is it fast food/fried food? _____

What change do you think is most needed to succeed after surgery?

Diet? _____ Explain _____

Exercise? _____ Explain _____

Patient Name: _____ Date of Birth: _____
(Last) (First)

Norton Healthcare

Psychological History for **Bariatric Surgical** **Assessment**

Patient Name: _____ Date of Birth: _____
(Last) (First)

PSYCHOLOGICAL PROFILE

How long have you been considering bariatric surgery? _____

How did you research the surgery? _____

Have you ever forced yourself to vomit after overeating? _____

Have you ever forced yourself to vomit to lose weight? _____

If yes, when was the last time you forced yourself to vomit to lose weight? _____

Do you eat in response to boredom, stress, fatigue, tension, depression, anger, anxiety or loneliness?

Do you eat because the opportunity is there, even when you are not hungry? _____

Do you eat as a result of negative self-worth? _____

Do you eat in response to physical cues (for example: increased hunger due to skipping meals or eating to cure headache or other pain)? _____

What words best describe what food means to you (check all that apply):

Survival _____ Comfort _____ Energy _____ Love _____

Companionship _____ Calming _____ Other (specify) _____

Who can you count on to provide you with emotional and physical support while you are in the hospital for surgery and after you go home during the weight loss process:

Have you **ever** been treated for psychiatric problems (depression, anxiety, bipolar disorder, schizophrenia)?
yes _____ no _____

Have you ever been to the emergency room for psychiatric problems? _____

If so when? _____

Have you ever been hospitalized for psychiatric problems? _____

If so when? _____

Are you currently seeing a psychiatrist? _____

Are you currently seeing a counselor? _____

Patient Name: _____ Date of Birth: _____
(Last) (First)

Are you currently taking medications (antidepressants, anti-psychotics, anti-anxiety, mood stabilizers) for psychiatric problems? _____

If so please list these medications: _____

What is the name of the professional prescribing these medications? _____

If you are currently taking psychiatric medications, please have the professional treating you with medications or counseling fill out and return to the Norton Bariatric Center the attached form entitled Behavioral Health Information Form. If you are not prescribed psychiatric medications, but see a counselor, please have that professional complete the form.

Do you take more of your medication than prescribed? _____

If so which medications _____

Do you take illegal drugs (street drugs or medications prescribed for someone else)?
_____ If so which drugs? _____

Have you ever been a victim of: Sexual abuse _____, Physical abuse _____, Emotional abuse _____,
Other abuse _____

If yes to above please briefly explain:

Please check the following symptoms you are **now** experiencing:

- ____ Anxiety
- ____ Depression
- ____ Current suicidal thoughts
- ____ Current homicidal thoughts
- ____ Sleep problems (if checked please indicate: too much____, too little____)
- ____ Loss of energy
- ____ Appetite problems (if checked please indicate: too much____, too little____)
- ____ Guilty thoughts
- ____ Loss of interest in usual activities
- ____ Difficulty in concentrating
- ____ Feelings of worthlessness
- ____ Feelings of helplessness
- ____ Feelings of being too high or speeded up
- ____ Confusion
- ____ Hearing voices or seeing things other people do not see
- ____ Feeling physically keyed up
- ____ Feeling someone is trying to harm me
- ____ Feeling someone is controlling me
- ____ Anger or hostility to others

Patient Name: _____ Date of Birth: _____
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Please check any of these stressors that are **currently** bothering you:

- _____ Job
- _____ Move
- _____ Separation or divorce (yours)
- _____ Divorce or separation of someone close to you
- _____ Death of a loved one
- _____ Your physical condition
- _____ Physical condition of a loved one

Conflicts with:

- _____ Offspring
- _____ Parents
- _____ Spouse
- _____ Neighbors
- _____ Co-worker
- _____ Boss

- _____ Sexual problems
- _____ Legal problems
- _____ Other stressors

Do you have ADD/ADHD or any other learning difficulty which requires special instructions for this surgical process? _____

If so please describe what you will need: _____

Patient Name: _____ Date of Birth: _____
(Last) (First)



Medically Supervised Weight Loss Request Letter

Dear Colleague,

Patient: _____, DOB: _____ is being seen for consideration of bariatric surgery, either laparoscopic adjustable gastric banding or Roux-en-Y gastric bypass. From our assessment and in compliance with the National Institute of Health (NIH) criteria this patient meets all basic criteria for consideration, however, at this time the patient's insurance is requiring your patient to undergo _____ consecutive months of physician supervised and documented weight loss prior to being eligible for surgical services. While we understand that most patients have a long history of unsuccessful weight loss management for numerous reasons, we must comply with their guidelines.

Enclosed you will find a simple assessment form to be completed on each medical visit. We hope this form will make assessing your patient easier as well as provide consistency in fulfilling the insurance requirements to expedite your patient's surgical needs.

Simply complete the enclosed form and fax back to us at **(502) 895-2675** each month the patient visits your practice.

If you have any questions or comments, please do not hesitate to contact us.

Sincerely,

The Norton Weight Management Services Team
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6500

Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit – Month 1

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if

appropriate: _____

Addition Comments and/or

recommendations: _____

Physician Signature: _____ **Date:** _____

Norton Weight Management Services

1000 Dupont Rd.

Louisville, KY 40207

(502) 899-6500

FAX: (502) 895-2675

Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit - Month 2

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if appropriate: _____

Addition Comments and/or recommendations: _____

Physician Signature: _____ **Date:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6500
FAX: (502) 895-2675

Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit - Month 3

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if appropriate: _____

Addition Comments and/or recommendations: _____

Physician Signature: _____ **Date:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6500
FAX: (502) 895-2675

Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit - Month 4

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if appropriate: _____

Addition Comments and/or
recommendations: _____

Physician Signature: _____ **Date:** _____

Norton Weight Management Services
1000 Dupont Rd.
Louisville, KY 40207
(502) 899-6500
FAX: (502) 895-2675

Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit - Month 5

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if appropriate: _____

Addition Comments and/or recommendations: _____

Physician Signature: _____ **Date:** _____

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Patient Name: _____ Date of Birth: _____
(Last) (First)

Physician Supervised Weight Loss Visit - Month 6

Patient Name: _____ Date: _____

DOB: _____ Physician: _____

HT: _____ WT: _____ BP: _____ TEMP: _____ Pulse: _____

Diagnosis: 1) _____ 2) _____ 3) _____

Current Dietary

Program: _____

Physical Activity/Exercise

Program: _____

Behavioral

Interventions: _____

Consideration of or use of Pharmacotherapy w/FDA approved medication if appropriate: _____

Addition Comments and/or recommendations: _____

Physician Signature: _____ **Date:** _____

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