

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)



**NORTON**  
WEIGHT MANAGEMENT  
SERVICES

**NORTON**  
**HEALTHCARE**

**BARIATRIC CENTER**  
**PATIENT PACKET**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

Welcome to Norton Healthcare 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) 629-5626.

We look forward to assisting you.

Mail completed information to:  
**Norton Healthcare Bariatric Center**  
**Norton Medical Pavilion**  
**315 E. Broadway, M-11**  
**Louisville, KY 40202**  
**Telephone: (502) 629-5626**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

## **PATIENT INFORMATION SHEET**

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  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: \_\_\_\_\_  
 (Last) (First)

**INSURANCE INFORMATION**

**PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH FRONT & BACK, WHEN SUBMITTING THIS FORM. IF YOU HAVE MULTIPLE INSURANCE CARDS, PLEASE INDICATE WHICH POLICY IS YOUR PRIMARY.**

**Disclaimer:**

- The Norton Healthcare Bariatric Program 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 you contact the customer service number on your card in order to better understand the benefits specific to your insurance policy.**

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) 629-5626.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

**PLEASE CHECK BELOW IF YOU HAVE A HOSPITAL/SURGEON PREFERENCE**

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

NO HOSPITAL OR SURGEON PREFERENCE/FIRST AVAILABLE

**IF YOU MARKED A SURGEON, PLEASE TELL US WHY:**

- Physician Referral       Word of Mouth       Website  
 Other \_\_\_\_\_

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**PLEASE CHECK THE SURGERY IN WHICH YOU ARE INTERESTED**

- OPEN GASTRIC BYPASS  
 LAPAROSCOPIC GASTRIC BYPASS  
 LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING
- 
-

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

### **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 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**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

## SAMPLE PHYSICIAN LETTER OF SUPPORT

**This form 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 Bariatric Center can provide forms your physician can use to document these visits.

**PREVIOUS BARIATRIC SURGERIES?**

If Yes, please list procedure, date, surgeon and any complications:

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**PREVIOUS SURGERIES (NON-BARIATRIC)**

- |  |  |   |
|--|--|---|
| <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                     |  |   |

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

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

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**CURRENT MEDICATIONS: (Prescription, over-the-counter, vitamins, herbal, etc.) PLEASE PRINT**

**Drug Name:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Multiple Vitamin    Calcium    Vitamin B-12    Iron    Vitamin D    Vitamin A, D, E Combo    Calcium w/Vit D

**ANY ADDITIONAL MEDICATIONS, PLEASE LIST ON BACK OR ATTACH SEPARATE SHEET**

\*\*\*\*\*

**ALLERGIES:**

**DO YOU HAVE A LATEX OR SILICONE ALLERGY?   YES   NO   DON'T KNOW**

**LIST ALL ALLERGIES (Medications, foods, environmental, etc.)   and   TYPE OF REACTION**

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**SMOKING HISTORY:** Currently smoke? Yes / No Did you ever smoke? Yes / No  
How long since you quit? \_\_\_\_\_ Number of pack(s) per day \_\_\_\_\_ Years as smoker? \_\_\_\_\_

\*\*\*\*\*

**MEDICAL HISTORY: Have you ever been diagnosed with the following?**

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
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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

Asthma..... Yes No

COPD..... Yes No

**GASTROINTESTINAL PROBLEMS:**

Heartburn..... Yes No

Ulcers..... Yes No

Nausea/vomiting..... Yes No

Rectal bleeding/dark stools..... Yes No

Abdominal pain..... Yes No

Diarrhea/constipation..... Yes No

NASH ..... Yes No

Hepatitis..... Yes No

Cirrhosis..... Yes No

**GENITOURINARY PROBLEMS:**

History of kidney stones..... Yes No

**BLOOD ISSUES:**

Anemia..... Yes No

Bleeding disorder..... Yes No

Blood clots in legs or lungs..... Yes No

**ENDOCRINE PROBLEMS:**

Thyroid disease..... Yes No

**NEUROLOGICAL PROBLEMS:**

Seizures..... Yes No

Headaches..... Yes No

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (Last) (First)

**SKIN PROBLEMS:**

Eczema.....Yes No

**MUSCULOSKELETAL PROBLEMS:**

Back pain.....Yes No

Joint pain.....Yes No

**FOR FEMALES ONLY:**

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

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Miscarriages \_\_\_\_\_

**ANESTHESIA HISTORY:**

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

Have you ever had any problems with anesthesia? .....Yes No Explain \_\_\_\_\_

**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				

**ALCOHOL CONSUMPTION: YES / NO FREQUENCY: \_\_\_\_\_ HOW MUCH PER WK? \_\_\_\_\_**

**HISTORY OF SUBSTANCE ABUSE? YES / NO**

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

**IF YES, GIVE DETAILS OF TREATMENT:**

**WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_**

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:

What is your current weight in pounds? \_\_\_\_\_

What is your current height? Feet: \_\_\_\_\_ Inches: \_\_\_\_\_

How many years have you been overweight? \_\_\_\_\_

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? \_\_\_\_\_

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)

Please Check and Provide Information For All That Apply

Medically Supervised Diet Programs:

	# of Attempts	When	Length of Time	Weight Loss	Regained?
Medi-Fast	_____	_____	_____	_____	_____
Opti-Fast	_____	_____	_____	_____	_____
Fen/Phen	_____	_____	_____	_____	_____
Redux	_____	_____	_____	_____	_____
Meridia	_____	_____	_____	_____	_____
Behavior Modification	_____	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____	_____
Dietitian Recommended	_____	_____	_____	_____	_____

Non-MD Supervised Program:

	# of Attempts	When	Length of Time	Weight Loss	Regained?
Weight Watchers	_____	_____	_____	_____	_____
Nutri-Systems	_____	_____	_____	_____	_____
Jenny Craig	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Liquid Diets:

	# of Attempts	When	Length of Time	Weight Loss	Regained?
Slimfast	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Miscellaneous Diets:

	# of Attempts	When	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)

# **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 loose 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? \_\_\_\_\_

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First)

If so please list these medications: \_\_\_\_\_

**If you are currently taking psychiatric medications, or if you are currently in counseling, 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.**

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: \_\_\_\_\_  
(Last) (First)

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)

### Behavioral Health Information Form

**The following form needs to be filled out by the professional prescribing mental health medications. If you are not taking mental health medications but are seeing a therapist, please have your therapist fill out the form.**

Mr./Ms. \_\_\_\_\_ is currently in treatment with me. The patient's diagnosis is

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

The patient is being treated with the following mental health medication(s):

\_\_\_\_\_  
\_\_\_\_\_

In my opinion, this patient is

mentally stable                      yes \_\_\_\_\_ no \_\_\_\_\_,

compliant with treatment        yes \_\_\_\_\_ no \_\_\_\_\_,

and has the cognitive and emotional ability to undergo bariatric surgery and to  
follow aftercare recommendations                      yes \_\_\_\_\_ no \_\_\_\_\_.

Signed: \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Direct phone number where we can reach you for further information:

\_\_\_\_\_

Date: \_\_\_\_\_

**Please return this completed form by mail or fax to:**

Norton Bariatric Center  
315 East Broadway M-11  
Louisville, KY 40202  
Phone: (502) 629-5626  
Fax: (502) 629-5290