Dignity Health.
Mercy Hospitals

Bariatric Surgery Data Collection

Name: _____

DOB: _____ **Age:** _____

Please fill out the following information:

Gender: ☐ Male ☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ American Indian or Alaska Native
☐ Asian
☐ African American
☐ Native Hawaiian or Pacific Islander
☐ Caucasian
☐ Prefer not to answer

Smoked in the last year: ☐ Yes ☐ No

Please check if you have any of the following:
☐ Diabetes: ☐ Insulin ☐ Non-insulin
☐ Sleep apnea
☐ History of pulmonary embolism
☐ Previous cardiac catheterization, heart attack or heart surgery
☐ Venous stasis
☐ History of blood clots
☐ Currently on blood thinners
☐ Severe COPD
☐ High blood pressure on medication
☐ High cholesterol
☐ GERD
☐ Dialysis
☐ Previous bariatric surgery
☐ Steroid use for a chronic condition

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WEIGHT LOSS SURGERY PROGRAM CONTRACT
Between
Name: _____ and Mercy Weight Loss Surgery Program

This contract is written solely for the benefit of the patient to assist him/her in obtaining the best results possible after Bariatric Surgery. Surgery alone does not work in reducing weight. Weight loss requires lifelong and significant changes in habits. The patient agrees to abide by and adhere to the following principles:

Diet Commitment

1. Adhere to a low carb, 1200-1500 calorie diet, or as instructed by your surgeon or dietitian
2. Weight Loss minimum of 5-10lbs or as instructed by your surgeon from initial consultation to insurance submission
3. To AVOID soft or melted ice cream, junk food or high carb food and high calorie liquids
4. To eat only to the point of feeling full or satisfied
5. Daily food journals that can be submitted to insurance as supporting documentation or to be reviewed by your primary MD or dietitian at monthly weight management visits
6. To utilize vitamin and protein supplements for life and be monitored with blood work and physical exams for life

Exercise Commitment

7. To exercise 3-5 days per week for 30 minutes continuously starting at pre-op
8. Weekly record of weights

Medication/Cessation Commitment

9. To STOP smoking and/or STOP ALL illegal/ illicit drug use
10. Drug screening if indicated
11. To NOT take non-steroidal anti-inflammatory medications such as Motrin, Ibuprofen, Aleve, Naproxen & alka seltzer, for life following gastric bypass surgery and refrain from using until cleared by your surgeon for the gastric sleeve (Tylenol is ok)

Behavioral Modification/ Follow up

12. To attend 4 Support Group Meetings before &/or after surgery per year
13. To keep follow-up appointments as recommended by your surgeon OR if out of town, to maintain follow up with your surgeon by phone

Please initial your understanding of the following:

_____ I understand that I will need *consecutive* monthly weight management visits

_____My surgeon has explained to me the risks & benefits of bariatric surgery.

_____ I commit and understand that I need to make the life style changes necessary to achieve my ideal body weight as instructed above.

FAILURE TO ABIDE BY THESE PRINCIPLES WILL BE CONSIDERED NON-COMPLIANCE BY THE PATIENT AND THE PATIENT MAY BE DEEMED A POOR CANDIDATE FOR SURGERY BY THE SURGEON OR THEIR INSURANCE & RESULT IN CANCELLATION OR DELAY IN SURGERY.

BY SIGNING THIS CONTRACT, I AM ACKNOWLEDGING THAT I FULLY UNDERSTAND THE ABOVE AND AGREE TO ADHERE TO ALL OF THE ABOVE FOR LIFE.

Patient Signature: _____ Date: _____

Program Coordinator Signature: _____

Appointment and Office Reminder Authorization Form

Email

I authorize Mercy Hospital to send appointment reminders and/or office notifications electronically via email to the following email address:

Email Address:

_____

Text Message

I authorize Mercy Hospital to send appointment reminders and/or office notifications electronically via text message to my mobile phone. I understand this service is free of charge. However, standard text messaging rates from your mobile carrier may apply.

I am authorizing Mercy Hospital to activate text message reminders for the mobile phone number listed below:

Mobile phone number:

_____

Voice Message

I authorize Mercy Hospital to contact me for appointment reminders and/or office notifications via voice messaging. If I am unavailable to answer the telephone, I give Mercy Hospital permission to leave a message on my answering machine or with the person answering the telephone.

_____ Initial if ok to call mobile phone number listed above

Phone number:

_____ (If different from mobile phone number)

By signing below, you are allowing Mercy Hospital to contact you for appointment reminders and/or office notifications from the information provided above.

All our means of contact will be HIPPA compliant.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Mercy Hospitals of Bakersfield
Weight Loss Surgery Program
Phone: 661-632-5117 | Fax: 661-244-8207
2103 Truxtun Ave
Bakersfield, CA 93301

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL CHART

Patient Name _____ DOB _____

Daytime Phone Number_____

I HEREBY AUTHORIZE RECORDS RELEASED FROM:

_____
(Name of person or organization releasing information)

_____
Street Address

_____
City State Zip Code

RELEASE MEDICAL RECORDS AND HEALTH INFORMATION TO:

Mercy Hospital Weight Loss Surgery Program
(Name of person or organization information is going to)
2103 Truxtun Ave, Bakersfield, CA 93301

Phone: 661-632-5117 Fax records to 661-244-8207

_____ I agree to allow this office to obtain & share clinical & demographic information electronically with other healthcare providers such as: Surgeons, Hospitals, Primary Care Physicians, or any other applicable provider/physician as needed to facilitate my medical care.

THIS RELEASE LIMITS DISCLOSURE TO:
☒Progress Notes ☒Consultation Notes ☒Lab/ Pathology Reports ☒Radiology/ Imaging Reports
Other: _____
Information not to be released, if any: _____

FOR THE FOLLOWING DATES: _____

This information is required for:
☒Pre-Op workup for Weight Loss Surgery ☐Other: _____

This authorization shall be valid until _____. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 6 months.
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment as stated above. I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Dept. I understand that the revocation will not apply to information that has already been released to this authorization. I understand that the revocation will not apply to my insurance co. when the law provides my insurer with the right to contest a claim under my policy.
Either treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide the authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

PATIENT SIGNATURE _____ DATE _____

Dignity Health.
Mercy Hospitals

Name:_____

DOB:_____

In preparing for your dietitian evaluation and weight management class, please answer the following questions:

1. **Number of years overweight/obese: _____**

2. **Maximum amount of weight loss previously: _____**

3. **What was your heaviest weight? _____**

4. **What diets, appetite suppressants, programs, or surgeries have you tried to lose weight in the past (please list)**

   _____

   _____

   _____

5. **Special diets prescribed by a health care professional (please list)**

   _____

   _____

   _____

6. **How much weight was regained after your previous diets? _____**

7. **Do you have any limitations related to exercise? _____**

   If yes, please explain: _____

8. **Food Allergies, chewing or swallowing problems, food intolerances? (please list)**

   _____

   _____

   _____