

#### Freeman Bariatric Center Online Seminar Instructions:

- Go to [freemanhealth.com/bariatric](http://freemanhealth.com/bariatric) and scroll to the heading titled “Helpful Resources.” Click the “Watch our Seminar” tab and click on the red arrow. It is encouraged to explore the entire page for additional information about our program and helpful information to assist you in your bariatric journey.
- Fill out the paperwork that is located underneath the seminar. You can edit this information on your chosen device and save the document. You can either email to [bariatric@freemanhealth.com](mailto:bariatric@freemanhealth.com), fax directly to the Bariatric program at 417.347.5107 or mail back in a postage paid envelope that was included with your mailed packet.
- Papers to complete are listed as:
  - Eight pages of medical information
  - New Patient/Update – Please fill out completely and sign and date. This is very important for our insurance representative to accurately determine your insurance coverage and requirements that must be met.
  - Authorization for Release of Information – Please fill out and sign and date. This form is utilized to legally request records outside of Freeman Health System .
  - Please copy and/or attach a copy of your insurance card (front and back) and the front of a photo ID.
  - If you don’t have the ability to do the above, please call 417.347.1266 to schedule an in-person seminar or personal appointment to view the seminar in the office.
  - If we have mailed you the above-mentioned forms, please return them in the enclosed postage paid envelope. Keep the folder with the business card and support group information. You are welcome to attend support group at any stage of the program.
  - After your packet is received, it will be reviewed by the Bariatric team to determine if you are a candidate for the program in accordance to your insurance guidelines. Our insurance representative will call you with an explanation of your insurance benefits and requirements. They will also schedule your first nutrition appointment.
  - If you prefer you may deliver to our office located at 3302 McIntosh Circle Suite 1, Joplin, MO 64804

Please don’t hesitate to call 417.347.1266 with any questions or concerns. We look forward to assisting you with any needs you may have to be successful in every step of your journey! We will contact you periodically to check your progress and see how your journey is going throughout the bariatric process.

## PATIENT INFORMATION (Please Print)

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

Preferred Procedure: Gastric sleeve\_\_\_\_ Roux-en-Y (Bypass)\_\_\_\_ Duodenal Switch\_\_\_\_

First Name: \_\_\_\_\_ Middle Intl: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Sex: M F Status: S M D W Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native

☐ Native Hawaiian, other Pacific Islander ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic/Latino ☐ Not-Hispanic/Latino ☐ Declined ☐ Unknown

Primary Language: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Position (Job Title): \_\_\_\_\_ Length of Employment: \_\_\_\_\_

## PRIMARY CARE PHYSICIAN

Doctor's Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

How long has this doctor provided your medical care? \_\_\_\_\_

If you have no preference and haven't already been seen by one of the physicians – you will be assigned a physician.

How were you referred to the program? \_\_\_\_\_

## CO-OCCURRING MEDICAL ISSUES

Please answer all questions related to your current and/or past medical history.

Place an 'X' beside Yes or No for *every* question.

<u>Cardiovascular Disease</u>	<u>Yes</u>	<u>No</u>	<u>RN/MD Notes (for office use only)</u>
High Blood Pressure	_____	_____	_____
Congestive Heart Failure	_____	_____	_____
Ischemic Heart Disease	_____	_____	_____
Heart Stress Test	_____	_____	_____
Heart Attack	_____	_____	_____
Stents Placed in Heart	_____	_____	_____
Heart Catheterization	_____	_____	_____
Anginal Chest Pain	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Stroke	_____	_____	_____
Lower Leg Edema/Swelling	_____	_____	_____
Blood Clot in Leg or Lung	_____	_____	_____
Vena Cava Heart Filter	_____	_____	_____
Coagulation/Bleeding disorders	_____	_____	_____

<u>Metabolic Disease</u>	<u>Yes</u>	<u>No</u>	
Diabetes Mellitus Type I	_____	_____	_____
Diabetes Mellitus Type II	_____	_____	_____
Fasting glucose > 99 mg/dL	_____	_____	_____
Oral Medication for Diabetes	_____	_____	_____
Insulin Use	_____	_____	_____
Eye/Kidney Problems	_____	_____	_____
High Cholesterol or Lipids	_____	_____	_____
Gout/High Uric Acid Levels	_____	_____	_____

<u>Pulmonary</u>	<u>Yes</u>	<u>No</u>	
Sleep Study	_____	_____	_____
Sleep Apnea	_____	_____	_____
CPAP/BIPAP Use	_____	_____	_____
Oxygen Use at Home	_____	_____	_____
Pulmonary Hypertension	_____	_____	_____
Asthma	_____	_____	_____
Inhaler Use Due to Asthma	_____	_____	_____

<u>Gastrointestinal</u>	<u>Yes</u>	<u>No</u>	
Heartburn/Reflux/GERD	_____	_____	_____
Heartburn Medication Use	_____	_____	_____
Past Anti-Reflux Surgery	_____	_____	_____
Barrett's Esophagus	_____	_____	_____
Crohn's Disease or Colitis	_____	_____	_____
Gallstones	_____	_____	_____
Gallbladder Removal	_____	_____	_____
Abnormal Liver Tests	_____	_____	_____

<u>Musculoskeletal</u>	<u>Yes</u>	<u>No</u>	
Back Pain	_____	_____	_____
Back Pain Requiring Meds	_____	_____	_____
Hip, Knee, Ankle Pain	_____	_____	_____
Joint Pain Requiring Meds	_____	_____	_____
Fibromyalgia	_____	_____	_____
Joint Replacement	_____	_____	_____
Back Surgery	_____	_____	_____

<u>Reproductive (Female)</u>	<u>Yes</u>	<u>No</u>	
Polycystic Ovarian Syndrome	_____	_____	_____
Infertility	_____	_____	_____
Menstrual Irregularities	_____	_____	_____
Hysterectomy	_____	_____	_____

<u>General</u>	<u>Yes</u>	<u>No</u>	
Stress Urinary Incontinence	_____	_____	_____
Sanitary Pad Use for Leakage	_____	_____	_____
Pseudotumor Cerebri	_____	_____	_____
Abdominal Hernia	_____	_____	_____
Hernia Repair	_____	_____	_____
Walk with a Cane/ Walker	_____	_____	_____
Sores/Rash in Skin Folds	_____	_____	_____
Past Weight Loss Surgery	_____	_____	_____

**FAMILY HISTORY** of medical problems (parents, grandparents, siblings, aunts and uncles).

Please mark all that apply

\_\_\_ High Blood Pressure

\_\_\_ Stroke

\_\_\_ Heart Disease or Heart Attack

\_\_\_ Obesity

\_\_\_ Cancer

\_\_\_ Bleeding Disorder

\_\_\_ Diabetes

\_\_\_ Clotting Disorder

## EXERCISE

Do you have any physical limitations that make it difficult or impossible for you to exercise? Y N

Do you have difficulty with basic mobility or self-care? Y N

Do you use any of the following assistive devices? Y N

If yes, please check all that apply:

- ☐ Cane or walker
- ☐ Wheelchair or mobility scooter
- ☐ Crutches or Brace
- ☐ Prosthetic Device
- ☐ Oxygen

## MEDICATIONS Currently Taking (Include prescriptions, OTC, vitamins and herbs)

Name	Dose	Frequency	Purpose	Start Date

List **ANY RECENT** labs, x-rays, EKGs, stress tests or echocardiograms with date and location.

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**ALLERGIES** to medications, latex or other substances

Substance	Reaction to substance (rash, breathing, etc.)

List any **SURGERY** (Please write 'Lap' if done laparoscopically)


List **ANY OTHER** medical problems/surgeries not listed above:

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**DIET HISTORY**

Weight History (Highest weight each year, in pounds)

2021\_\_\_\_\_ 2020\_\_\_\_\_ 2019\_\_\_\_\_ 2018\_\_\_\_\_ 2017\_\_\_\_\_

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

How many years have you been trying to lose weight? \_\_\_\_\_

How long have you been researching or thinking about weight loss surgery?\_\_\_\_\_

Why are you seeking weight loss surgery? \_\_\_\_\_

What has been your lowest adult weight?\_\_\_\_\_ Highest adult weight?\_\_\_\_\_

Do you have any religious or cultural beliefs that affect what you eat? Y N

If yes, describe \_\_\_\_\_

**Please fill out the diet history form completely, with as much detail as possible. The information on this form is used for your Medical Necessity letter that is submitted to your insurance company. Documentation should reflect ALL weight loss efforts attempted, including physician supervised, commercial programs, prescription diet pills, behavior modification, unsupervised diets and over-the-counter diet aids.**

Program	Date	Duration	Dr. Supervised?	Max Wt. Loss	Wt. Gained Back
Jenny Craig					
Nutri-System					
Weight Watchers					
Optifast/Medifast					
Fen-Phen/Redux					
Meridia					
Alli					
Bulimia/Purging after eating					
Anorexia					
T.O.P.S.					
O.A.					
Acupuncture					
Metabolife					
Atkins Diet					
Pritikin Diet					
South Beach Diet					
Low-Fat Diet					
Doctor Supervised Diets					
Zone Diet					
Beverly Hills Diet					
Grapefruit Diet					
HCG Diet					
Paleo Diet					
Keto Diet					

## PSYCHIATRIC HISTORY Symptom Checklist

**None** = This symptom is not currently present.

**Past** = This symptom is not currently present but has been experienced in the past five years.

**Mild** = This symptom is currently present but does not significantly impact my daily life.

**Moderate** = This symptom is currently present and significantly impacts my daily life.

**Severe** = This symptom is currently present and has a profound impact on my daily life.

	None	Past	Mild	Moderate	Severe
Depressed Mood					
Anxiety					
Appetite/Weight Changes					
Problems with Sleep					
Nightmares					
Flashbacks					
Poor Concentration					
Lack of Energy/Motivation					
Difficulty with Social Interactions					
Relationship Conflict					
Mood Swings					
Irritability					
Poor Grooming					
Panic Attacks					
Phobias					
Obsessions/Compulsions					
Binging/Purging					
Anorexia					
Paranoia					
Delusions					
Hallucinations					
Aggressive Behavior					
Sexual Dysfunction					
Grief					
Feelings of Hopelessness					
Feelings of Worthlessness					
Guilt					
Hyperactivity					
Anger/Rage					
Self-Harm Behaviors					
Thoughts of Suicide*					
Thoughts of Homicide*					
Verbally/Emotionally Abusive Towards Others					
Physically Abusive Towards Others					
Sexually Abusive Towards Others					
Other					

*\*If you are currently having thoughts of harming yourself or someone else, please contact our Crisis Intervention Hotline immediately at 417-347-7720 or 1-800-247-0661*

**MENTAL HEALTH AND READINESS FOR SURGERY QUESTIONS**

PLEASE RESPOND TO ALL ITEMS

1. Have you been hospitalized for any psychiatric reason (i.e., suicide attempt, severe depression)
 

a. Within the past 12 months?	YES	NO
b. In the past 2 years?	YES	NO
c. In the past 5 years?	YES	NO

2. In the last 12 months, have you experienced (**circle one**)
 

a. Auditory hallucinations (i.e., do you hear voices other people cannot hear?)	YES	NO
b. Visual hallucinations (I.e., do you see things that other people cannot see)	YES	NO

3. Have you ever been **diagnosed with and/or treated for** mental or emotional concerns including (**circle all that apply**)
  - a. Depression/mood disorder
  - b. Anxiety/panic disorder
  - c. Eating disorders
  - d. Schizophrenia/schizoaffective disorder
  - e. Alcohol or substance use disorder
  - f. Memory impairment

If **yes**, please list the name of the provider or organization, dates you were treated and diagnosis (if you are aware of it).

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4. Have you ever done any of the following to lose weight: (**please list if past or current**)

- |  |     |    |      |         |
|--|-----|----|------|---------|
| a. Purge (i.e., self-induced vomiting)                       | YES | NO | PAST | CURRENT |
| b. Use laxatives or diuretics                                | YES | NO | PAST | CURRENT |
| c. Engage in excessive exercise<br>(i.e., over 1 hour a day) | YES | NO | PAST | CURRENT |

5. If applicable please list the name and organization of the mental health provider/psychiatrist/nurse practitioner who prescribes your mental health medications.

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Please complete the following.

Alcohol use: ☐ None ☐ Rare (1-2/month) ☐ Occasional (3 or less/week) ☐ Frequent (4+/week)

Tobacco use: ☐ None ☐ Rare (1-2/month) ☐ Occasional (3 or less/week) ☐ Frequent (4+/week)

☐ Packs per day (Cigarettes) ☐ Chew ☐ Y ☐ N If no, when did you quit? \_\_\_\_\_

☐ E-cigarette ☐ Nicorette Gum

Substance Abuse: ☐ Y ☐ N

If yes, describe substance \_\_\_\_\_ Quit Date \_\_\_\_\_

☐ Marijuana ☐ Cocaine ☐ Crack ☐ Meth

☐ Other recreational drug \_\_\_\_\_

Do you have any religious or cultural beliefs that affect what you eat? ☐ Y ☐ N

If yes, please describe \_\_\_\_\_



## NEW PATIENT/ANNUAL UPDATE

### PATIENT INFORMATION: (Please Print)

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Intl: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Race: ☐ Unknown ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native  
☐ Native Hawaiian, Other Pacific Islander ☐ Other Primary Language: \_\_\_\_\_Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Misc. Phone 1: \_\_\_\_\_ Misc. Phone 2: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ S.S.#: \_\_\_\_\_ . \_\_\_\_\_ . \_\_\_\_\_ SEX: M F Marital Status: S M D W

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Position (Job Title): \_\_\_\_\_ How long employed?: \_\_\_\_\_

If Minor, Patient lives with: MOTHER FATHER GRANDPARENT FOSTER PARENT OTHER

### PERSON RESPONSIBLE FOR BILL: (If Minor, Parent or Guardian)

Date of

Name \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Position (Job Title): \_\_\_\_\_ How long employed?: \_\_\_\_\_

### SPOUSE INFORMATION:

Date of

Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Position (Job Title): \_\_\_\_\_ How long employed?: \_\_\_\_\_

### PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY: (Other than above)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

### INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

TERTIARY INSURANCE NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

☐ I acknowledge that I have had the opportunity to read and/or receive a copy of System's Notice of Privacy Practices. A complete copy of the Notice is available at the Admissions desk.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

01.70000.99600. PRCT.0050.0215



# Authorization for Release of Information

[roi@freemanhealth.com](mailto:roi@freemanhealth.com)

All sections of this authorization form **MUST** be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Maiden or other names: \_\_\_\_\_

**I request my protected health information (PHI) be released from:**

**Clinics ↓**

- ☐ Cornell-Beshore Cancer Institute  
☐ Freeman Heart Institute  
☐ Freeman Midwest Orthopedics  
☐ Freeman Nephrology and Dialysis  
☐ Freeman Wound Care

**Hospitals ↓**

- ☐ Freeman Hospital East and West  
☐ Freeman Neosho Hospital  
☐ Occumed

**ER and Urgent Care ↓**

- ☐ Emergency Room (Joplin and/or Neosho)  
☐ Urgent Care - Joplin  
☐ Urgent Care - Webb City

☒ **Other** (Specific Provider Location / Provider Name/ or Doc Type): \_\_\_\_\_

**I request my protected health information (PHI) be released to:**

Name: Freeman Bariatric Center Email: bariatric@freemanhealth.com

Address: 3302 McIntosh Circle, Suite 1 Phone: (417)347-1266

City/State: Joplin, MO Zip Code: 64804 Fax (immediate purposes only): (417)347-5107

**\* I authorize the following PHI to be released from my medical record(s):**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abstract/Pertinent Summary*<br>* dictated reports and test results | <input type="checkbox"/> Emergency Room Record<br><input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Itemized Billing<br><input type="checkbox"/> UB-04 Claim Form |
| <input checked="" type="checkbox"/> Complete Medical Record (all pages)                     | <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> 1500 Claim Form   |

☐ **Other:** \_\_\_\_\_

**Covering the period of health care from:**

☐ Specific Date(s): 01/01/2017 to 12/31/2022

**Purpose for requesting information:**

- ☐ Legal ☐ Insurance  
☐ Personal ☒ Continuation of Care

**How Information is to be received (if not marked, paper is default)**

- ☒ US Mail - paper format ☒ Fax (immediate purposes only)  
☒ CD - Secure electronic format ☐ Pick up copies in the Department  
☐ Email

**By signing this authorization form, I understand that:**

- \* Requests for copies of medical records and/or non-document material may be subject to copying fees.  
\* I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Medical Records Department at 1102 W. 32nd Street, Joplin, MO 64804. Revocation will not apply to information that has already been released in response to this authorization.  
\* Unless otherwise revoked, this authorization will expire on the following date/event/condition: 12/31/22.  
If I fail to specify an expiration date/event/condition, this authorization will expire within 90 days of the date signed.  
\* Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.  
\* Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.  
\* **I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and or HIV related conditions.** Patient Initial Here: X  
\* **I authorize the release of any info. pertaining to genetic testing to the person or organization described above.** Patient Initial Here: \_\_\_\_\_

☒ Patient/ Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ ☒

☒ Printed Name of authorized Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ ☒

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form\***





## Test Questions for Online Bariatric Seminar

Patient Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

1. Freeman Bariatric Center is a Comprehensive Program, meaning:
  - a. It is a program which includes nutrition, psychological support and support groups.
  - b. It is a program which includes availability of services, before and after surgery.
  - c. Both (a) and (b) are required by the Program and by insurance.
  - d. All of the above.
2. Freeman Bariatric Center is a Center of Excellence Accredited Program through the MBSAQIP.
  - a. True
  - b. False
3. Comorbidities which insurance and Freeman Bariatric Center may recognize:
  - a. Hypertension (high blood pressure)
  - b. Diabetes – Type 1 and Type 2
  - c. Sleep Apnea
  - d. All of the above
4. Who is a candidate for Bariatric Surgery?
  - a. At least 18 years old
  - b. BMI (body mass index) of 35 with associated comorbidity conditions or a BMI of 40 or greater
  - c. Must be able to walk
  - d. Approved through evaluation with nutrition and a psychiatric counselor
  - e. All of the above
5. Identify the types of Bariatric Surgeries performed at Freeman:
  - a. Sleeve Gastrectomy (VSG)
  - b. Roux-en-Y (Gastric bypass)
  - c. Duodenal Switch (DS)
  - d. All of the above
6. A liquid diet is followed before Bariatric Surgery for typically 1 week:
  - a. True
  - b. False
7. Risks following any Bariatric Surgery may include:
  - a. Bleeding
  - b. Infection
  - c. Injury to the staple line, causing a leak
  - d. All of the above
8. Nutritional education requirements include:
  - a. One-on-one session
  - b. Group sessions
  - c. Personal goals set with a dietician
  - d. All of the above

9. After Bariatric Surgery, changes must include:
  - a. Making the protein portion of your meal the first priority
  - b. Not using straws
  - c. Making hydration a priority
  - d. Taking vitamin supplements and calcium citrate
  - e. Not drinking fluids 30 minutes before and 30 minutes after a meal
  - f. All of the above
10. Disciplinary habits to begin practicing include which of the following:
  - a. Not using straws
  - b. Chewing food thoroughly
  - c. Logging your food and water intake
  - d. Starting an exercise regimen
  - e. All of the above
11. The Psychological Evaluation appointment should be made sometime after you start nutrition classes: You will call and schedule this on your own.
  - a. True
  - b. False
12. The purpose of the Psychological Evaluation is:
  - a. To assess your readiness for Bariatric Surgery.
  - b. To identify any mental health risk factors.
  - c. To help you be successful.
  - d. All of the above.
13. The results of the Psychological Evaluation will be:
  - a. Cleared.
  - b. Denied.
  - c. Conditionally cleared, with recommendations.
  - d. One of the above.
14. After completion of all nutrition classes and being cleared on your psychological evaluation the next step is:
  - a. An appointment with the surgeon.
  - b. Go to the movies.
  - c. A is the answer, but B is okay too.