Freeman Health System Bariatric Center

PATIENT INFORMATION (Please Print) Date: _____

Preferred Procedure: Gastric sleeve____ Roux-en-Y (Bypass)_____ LAP-BAND®_____

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? _____

Physician Preference: ___ Dr. Coy ___ Dr. Baker

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-OCCURING 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.

Cardiovascular Disease	Yes	No	RN/MD Notes (for office use only)
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	___	___	_____

Metabolic Disease	Yes	No	
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	___	___	_____

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

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

Musculoskeletal	Yes	No	
Back Pain	___	___	_____
Back Pain Requiring Meds	___	___	_____
Hip, Knee, Ankle Pain	___	___	_____
Joint Pain Requiring Meds	___	___	_____
Fibromyalgia	___	___	_____
Joint Replacement	___	___	_____
Back Surgery	___	___	_____

Reproductive (Female)	Yes	No	
Polycystic Ovarian Syndrome	___	___	_____
Infertility	___	___	_____
Menstrual Irregularities	___	___	_____
Hysterectomy	___	___	_____

General	Yes	No	
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	___	___	_____

Patient Initials:_____

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

Please mark all that apply

___High Blood Pressure
___Heart Disease or Heart Attack
___Cancer
___Diabetes
___Stroke
___Obesity
___Bleeding Disorder
___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

Patient Initials:_____

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

_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

Freeman Health System **Bariatric Center**

DIET HISTORY

Weight History (Highest weight each year, in pounds)

2012_____ 2013_____ 2014_____ 2015_____ 2016_____ 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					

Patient Initials:_____

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

Patient Initials:_____

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_____

Patient Initials:_____

FREEMAN Health System

NEW PATIENT/UPDATE Date of Birth: _____

PATIENT INFORMATION: (Please Print)

First Name: _____ Middle Intl: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Misc. Phone 1: _____ Preferred Contact Method: _____

Email: _____ Preferred Statement Method: (E) Electronic (P) Paper

Date of Birth: _____ Age: _____ S.S#: _____ - _____ - _____ SEX: M F Marital Status: S M D W

Race: ☐Unknown ☐Black, African American ☐Asian ☐White ☐American Indian, Alaska Native ☐Native Hawaiian, Other Pacific Islander ☐Other Primary Language: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Employer: _____ Employer's Address: _____

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

If Minor, Patient lives with: MOTHER / FATHER / GRANDPARENT / FOSTER PARENT / OTHER_____(circle one)

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

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

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

Name _____ S.S. #: _____ - _____ - _____ Date of Birth: _____

Relationship to Patient: _____ Address: _____

Phone: _____ Mobile Phone: _____ Email: _____

Employer: _____ Employer's Address: _____

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

SPOUSE INFORMATION:

Name: _____ SS#: _____ - _____ - _____ Date of Birth: _____

Phone: _____ Mobile Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____

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: _____

FREEMAN Health System

Authorization for Release of Information

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 Bariatrics Clin. Email: JKorake@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):**

- [ ] Abstract/Pertinent Summary*
  - * dictated reports and test results
- [ ] Complete Medical Record (all pages)
- [ ] Emergency Room Record
- [ ] Laboratory Reports
- [ ] Radiology Reports
- [ ] Itemized Billing
- [ ] Complete Billing

[ ] **Other:** _____

Covering the period of health care from:

[ ] Specific Date(s): _____ to _____

Purpose for requesting information:
- [ ] Legal
- [ ] Personal
- [ ] Insurance
- [ ] Continuation of Care

How Information is to be received (if not marked, paper is default)
- [ ] US Mail - paper format
- [ ] CD - Secure electronic format
- [ ] Fax (immediate purposes only)
- [ ] 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: _____.
  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:** _____
* **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

* R O I *

FREEMAN
Health System

Bariatric Center Mental Health and Readiness for Surgery Questions

NAME: _____ **DOB:** / /

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).

   _____
   _____
   _____

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 (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.

   _____

FREEMAN
Health System

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. Gastric Banding (Lap-Band)
   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 requirements include:
   a. One-on-one session
   b. Group sessions
   c. Personal goals set with a nutritionist
   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 Packet you receive should be completed before your appointment:
    a. True
    b. False
12. The purpose of the Psychological Evaluation is:
    a. To access 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. All of the above.
14. After your feedback session with the Psychological Provider, 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.