Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS
Bariatric & General Surgery
Phone: 214-775-1356 Fax: 214-613-2231

Patient Responsibilities

To Our Patients:

Our office staff verifies your insurance benefits prior to the initial visit to our office to insure benefits are available for treatment of morbid obesity. We also obtain the co-pay amount for a specialist visit, deductible information as well as the co-insurance percentage. The insurance company and employer set these amounts and they are deducted from any payments made to Dr. Kennedy for services rendered and we are required to collect those amounts from our patients.

For our new patients we will collect the office visit co-pay at the time of the visit based on the information we received from the insurance company.

For our established patients we will collect the office visit co-pay if applicable, as well as any outstanding balances due from previous procedures and/or surgery. Any payment collected prior to surgery or procedure by the office staff has been applied to the account balance. Any balance on the account is based on the explanation of benefits provided to us by insurance company. Any questions regarding a balance should be directed to the insurance company for explanation.

**Please be aware we require 24 hours notice if you are unable to attend your appointment. Please notify us by phone to avoid a $25.00 "No Show" fee. You can cancel your appointment with anyone that answers the phone or if after hours, you may leave a message and let us know if you need a call back to reschedule.*

**As a courtesy to all of our patients, please also be aware your appointment will be re-scheduled if you are a minimum of 15 minutes late.*

Our goal is to provide the best possible care for our patients and make the journey to a healthier life as smooth as possible.

Thank you,

Dr. Kennedy

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS
Bariatric & General Surgery
Phone: 214-775-1356 Fax: 214-613-2231

PATIENT REGISTRATION FORM

PLEASE FILL OUT ALL SECTIONS OF THIS FORM COMPLETELY TODAY'S DATE:_____

NAME LAST: _____FIRST:_____MIDDLE INITIAL: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____DRIVER LICENSE #:_____

HOME PHONE: _____CELL:_____WORK:_____

DATE OF BIRTH: ____/_____/_____GENDER: M F RACE: _____ SS#_____

MARITAL STATUS: _____SPOUSE/SIGNIFICANT OTHER NAME: _____DATE OF BIRTH:_____

E-MAIL (OPTIONAL)_____
(NOTE: By filling in your email you are hereby giving Kennedy Bariatrics staff permission to communicate with you via this email)

EMPLOYER INFORMATION

PLEASE CIRCLE ONE: FULL TIME PART TIME SELF EMPLOYEED HOMEMAKER STUDENT RETIRED DISABLED UNEMPLOYEED

EMPLOYER:_____OCCUPATION:_____

EMPLOYER ADDRESS:_____

WORK PHONE:_____WORK E-MAIL:_____

GUARANTOR INFORMATION

- LIST THE PERSON, OR INSURED NAME, RESPONSIBLE FOR THE BILL. USE FULL LEGAL NAME; NO NICKNAMES, PLEASE

RELATIONSHIP OF GUARANTOR TO PATIENT: SELF____ SPOUSE____ PARENT____ OTHER_____

NAME LAST: _____FIRST:_____MIDDLE INITIAL: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____DRIVER LICENSE #:_____

HOME PHONE: _____CELL:_____WORK:_____

DATE OF BIRTH: _____/_____/_____GENDER: M F SS#_____

MARITAL STATUS: _____SPOUSE/SIGNIFICANT OTHER NAME: _____DATE OF BIRTH:_____

E-MAIL:_____

PATIENT NAME:_____DATE OF BIRTH:_____

EMERGENCY CONTACT INFORMATION

NAME:_____RELATIONSHIP:_____

PHONE:_____DOES EMERGENCY CONTACT SHARE ADDRESS? YES NO

EMERGENCY CONTACT MAY RECEIVE INFORMATION ABOUT YOUR MEDICAL CONDITION.

REFERRING DOCTOR:_____PHONE:_____

INSURANCE INFORMATION

- PLEASE FILL OUT AS COMPLETELY AND CORRECTLY AS POSSIBLE, (AS ANY INCOMPLETE INFORMATION COULD LEAD TO DELAY IN PROCESSING) LIST PERSON, OR INSURED NAME, RESPONSIBLE FOR BILL, AND USE FULL LEGAL NAME; NO NICKNAMES, (SOME OF THIS INFORMATION CAN BE FOUND ON THE BACK OF THE CARD).
-

PRIMARY INSURANCE INFORMATION

INSURED NAME:_____DATE OF BIRTH:_____SS#:_____

PRIMARY INSURANCE COMPANY:_____PLAN TYPE:_____

INSURANCE ID NUMBER:_____GROUP NUMBER:_____

CLAIMS ADDRESS:_____

PROVIDER PHONE NUMBER:_____

NAME OF POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#:_____

SECONDARY INSURANCE INFORMATION

INSURED NAME:_____DATE OF BIRTH:_____SS#:_____

SECONDARY INSURANCE COMPANY:_____PLAN TYPE:_____

INSURANCE ID NUMBER:_____GROUP NUMBER:_____

CLAIMS ADDRESS:_____

PROVIDER PHONE NUMBER: _____

NAME OF POLICY HOLDER:_____RELATIONSHIP:_____

DATE OF BIRTH:_____SS#:_____

PATIENT NAME:_____DATE OF BIRTH:_____

YOUR INSURANCE CAN REQUIRE UP TO FIVE YEARS OF HISTORY. PLEASE GIVE US THE NAME, PHONE AND FAX NUMBER OF ALL THOSE PROVIDERS THAT WILL HAVE THOSE RECORDS.

PRIMARY CARE DOCTOR:_____PHONE:_____FAX:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

ADDITIONAL DOCTOR:_____ PHONE:_____FAX:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

ADDITIONAL DOCTOR:_____ PHONE:_____FAX:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

- ❖ PLEASE LET US KNOW WHERE YOU PREFER YOUR PERSCRIPTIONS TO BE FILLED AT.

PHARMACY NAME: _____PHONE:_____

- ➢ *I AUTHORIZE RELEASE OF MY MEDICAL RECORDS FOR USE IN PURSUING BENEFITS AND TO OTHER PHYSICIAN OFFICES AS DEEMED NECESSARY IN THE COURSE OF MY TREATMENT.*

HEALTH AND MEDICAL HISTORY

(PLEASE FILL OUT QUESTIONS AS COMPLETELY AS POSSIBLE)

WHAT IS THE REASON FOR YOUR VISIT?_____

WHAT TYPE OF BARIATRIC SURGERY ARE YOU INTERESTED IN? PLEASE CIRCLE YOUR CHOICE:

LAPAROSCOPIC ADJUSTABLE GASTRIC BAND LAPAROSCOPIC GASTRIC SLEEVE LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS

LAP BAND REMOVAL REVISION FROM LAP BAND TO SLEEVE OR BYPASS REVISION OF BYPASS TO BYPASS

OTHER:_____

HEIGHT:_____ WEIGHT:_____ BODY MASS INDEX:_____

IF YOU HAVE HAD A PREVIOUS BARIATRIC SURGERY, WHO WAS YOUR SURGEON: _____

ADDRESS: _____ PHONE: _____ FAX: _____

DID YOU HAVE YOUR AFTERCARE APPOINTMENTS/BAND FILLS WITH THE SAME SURGEON?: YES NO

IF NO – WHERE?_____

HOW MANY YEARS HAVE YOU BEEN AT YOUR CURRENT WEIGHT? _____

AT WHAT AGE DID YOU BECOME OVERWEIGHT?_____ YEAR?_____

WHAT WAS YOUR LOWEST ADULT WEIGHT?_____YEAR?_____

WHAT WAS YOUR HIGHEST ADULT WEIGHT?_____YEAR?_____

FOR FEMALES ONLY: ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? YES NO ARE YOU CURRENTLY PREGNANT? YES NO

TYPE OF CONTRACEPTION: _____LAST MENSTRUAL CYCLE: _____

PATIENT NAME: _____DATE OF BIRTH: _____

MEDICAL HISTORY CONTINUED

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST ALL._____

_____

LIST ALL MEDICATION YOU ARE TAKING, INCLUDING VITAMIN & MINERAL SUPPLEMENTS:

NAME OF DRUG	STRENGTH	FREQUENCY TAKEN	HOW LONG ON THIS MEDICATION

SURGICAL HISTORY

HAVE YOU EVER HAD: GALLBLADER SURGERY SPLEEN SURGERY ESOPHAGUS SURGERY STOMACH SURGERY HERNIA REPAIR SURGERY CAESARIAN SECTION ABDOMINAL HYSTERECTOMY SURGERY? PLEASE LIST ALL SURGERIES BELOW:

PROCEDURE	DATE	NAME OF SURGEON	FACILITY/HOSPITAL

PLEASE LIST ALL OTHER MEDICAL CONDITIONS, ILLNESS, OR IMPORTANT INFORMATION NOT MENTIONED PREVIOUSLY:_____

_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, PLEASE EXPLAIN.

_____

_____

WHAT CONCERNS YOU MOST ABOUT YOUR HEALTH?

_____

_____

PATIENT NAME:_____DATE OF BIRTH:_____

MEDICAL HISTORY CONTINUED – PLEASE CHECK ALL THAT APPLY

CONDITION	Y	N	YEAR	COMMENTS	CONDITIONS	Y	N	YEAR	COMMENTS
Abdominal wall hernia					Heart Murmur				
Angina					Hepatitis				
Anemia/Type?					Herniated Disk				
Anorexia					Hiatal Hernia				
Anxiety					Inguinal Hernia				
Asthma					HIV/AIDS				
Bulimia					Hypothyroidism				
Bipolar					High Blood Pressure				
Panic Disorder					Kidney Disease				
Blood transfusion/tattoo					Kidney Stones				
Chronic Obstructive Pulmonary Disease (COPD)					Migraines				
Cirrhosis					Multiple Sclerosis (MS)				
Colitis/Irritable Bowel/Crohns Disease					Neuropathy				
Congestive Heart Failure					Osteoarthritis				
Coronary Artery Disease					Obstructive Sleep Apnea				
Coronary Bypass Surgery					Use CPAP or BIPAP machine?				
Deep Venous Thrombosis (Blood Clots in Legs)					Osteoporosis				
Depression					Osteopenia				
Diabetes – Type 1					Arrhythmia (abnormal heartbeat)				
Diabetes – Type 2					Peptic Ulcer Disease/Bleeding Ulcers				
Gestational Diabetes					Peripheral Arterial Disease				
Pre-Diabetes					Pulmonary Embolism				
Elevated Cholesterol					Rheumatoid Arthritis				
Elevated Triglycerides					Seizure Disorder				
Emphysema					Systemic Lupus				
Esophagitis					Other Autoimmune Disorders				
Reflux Disease (Gerd)					Stress Urinary Incontinence				
Heart Attack (MI)					Leaking when cough or sneeze				
Heart Disease					Leaking with straining				

Medications you have taken for weight loss:

MEDICATION	DATES	DOSAGE	PHYSICIAN SUPERVISED	AMOUNT OF WEIGHT LOST
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux				
Xenical (Orlistat,Alli)				
Meridia (Sibutramine)				
Other				

All Diets you have tried:

PROGRAM	YEAR	DURATION	PHYSICIAN SUPERVISED	AMOUNT OF WEIGHT LOSS
JENNY CRAIG				
ATKINS				
WEIGHT WATCHERS				
NUTRISYSTEM				
SOUTH BEACH				
OTHER				

PATIENT NAME:_____DATE OF BIRTH:_____

HAVE YOU EVER BEEN TREATED FOR ANY EATING DISORDER? YES____ NO____. IF YES, PLEASE EXPLAIN:_____
_____
DO YOU SMOKE? YES_____ NO_____. IF YES, FOR HOW LONG? _____ HAVE YOU QUIT? YES____ NO____. YEAR QUIT_____
DO YOU USE ALCOHOL? YES____ NO____. HOW OFTEN? DAILY_____ WEEKLY_____ OCCASIONALLY_____ RARELY_____
HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE? YES____ NO____. IF YES, PLEASE EXPLAIN:_____
_____
IS YOUR SPOUSE /PARTNER SUPPORTIVE OF WEIGHT LOSS SURGERY?_____
IS YOUR FAMILY SUPPORTIVE OF WEIGHT LOSS SURGERY?_____

FAMILY MEDICAL HISTORY

CONDITION	MOTHER YES	MOTHER NO	FATHER YES	FATHER NO	SISTER YES	SISTER NO	BROTHER YES	BROTHER NO	OTHER YES	OTHER NO	YEAR	NOTES
DIABETES												
HYPERTENSION												
HYCHOLESTEROL												
DEPRESSION												
OBSTRUCTIVE SLEEP APNEA												
CORONARY ARTERY DISEASE												
ASTHMA												
CANCER												
EARLY DEATH												
THYROID DISEASE												
KIDNEY DISEASE												
SEIZURES												
BIPOLAR												
STROKE												
OTHER: PLEASE EXPLAIN												

PATIENT AND PROGRAM AGREEMENT

1) I AM READY TO PURSUE SURGERY AS AN OPTION OF TREATMENT FOR MY OBESITY.
2) I AGREE TO FOLLOW THE PROGRAM AS PRESCRIBED AND ACTIVELY PARTICIPATE IN MY AFTERCARE WITH COLLEEN KENNEDY, M.D.
3) I AGREE THAT I AM PRIMARILY RESPONSIBLE FOR REQUESTING AND OBTAINING ALL MEDICAL RECORDS REQUIRED BY INSURANCE IN A TIMELY MANNER FOR MY INSURANCE APPROVAL AND WILL FOLLOW UP BY INFORMING DR. KENNEDY'S STAFF OF ANY CHANGES TO MY INSURANCE STATUS, OR UP-DATES OF INSURANCE POLICIES - SUCH AS CHANGES OF INSURANCE FROM ONE CARRIER TO ANOTHER; AND GET A COPY OF THE NEW CARD TO THEM TO UPDATE THEIR SYSTEM.
4) I REALIZE THAT I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE IF MY INSURANCE COMPANY FAILS TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.

NAME:_____ SIGNATURE:_____DATE:_____
(Printed Name)

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO DR. COLLEEN KENNEDY, MD, OR THE PHYSICIAN INDIVIDUALLY FOR SERVICES RENDERED TO MY DEPENDENTS OR ME BY THE PHYSICIAN OR UNDER HER/HIS SUPERVISION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND WHETHER OR NOT THE SERVICES I AM TO RECEIVE ARE A COVERED BENEFIT. I UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR ANY CO-PAY OR BALANCE DUE TO DR COLLEEN KENNEDY, MD IS UNABLE TO COLLECT FROM MY INSURANCE CARRIER FOR WHATEVER REASON.

MEDICARE/MEDICAID/AARP/SECUREHORIZON INSURANCE BENEFITS:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THESE PROGRAMS IS CORRECT. I AUTHORIZE THE RELEASE OF ANY OF MY OR MY DEPENDENT'S RECORDS THAT THESE PROGRAMS MAY REQUEST. I HEREBY DIRECT THAT PAYMENT OF MY OR MY DEPENDENT'S AUTHORIZED BENEFITS BE MADE DIRECTLY TO DR. COLLEEN KENNEDY OR THE PHYSICIAN ON MY BEHALF.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I CERTIFY THAT I HAVE RECEIVED AND READ A COPY OF THE PATIENT INFORMATION PRIVACY POLICY. I HEREBY AUTHORIZE DR. COLLEEN KENNEDY, MD OR THE PHYSICIAN INDIVIDUALLY TO RELEASE ANY OF MY OR MY DEPENDENT'S MEDICAL OR INCIDENTAL NON-PUBLIC PERSONAL INFORMATION THAT MAY BE NECESSARY FOR MEDICAL EVALUATION, TREATMENT, CONSULTATION, OR THE PROCESSING OF INSURANCE BENEFITS.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I CERTIFY THAT I UNDERSTAND THE PRIVACY RISKS OF THE MAIL, PHONE CALLS, AND E-MAIL. I HEREBY AUTHORIZE DR. COLLEEN KENNEDY, MD OR A REPRESENTATIVE TO MAIL, CALL OR E-MAIL ME WITH COMMUNICATIONS REGARDING MY HEALTHCARE, INCLUDING BUT NOT LIMITED TO SUCH THINGS AS APPOINTMENT REMINDERS, REFERRAL ARRANGEMENTS, AND LABORATORY RESULTS. I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS AUTHORIZATION AT ANY TIME BY NOTIFYING DR. COLLEEN KENNEDY, MD OR THE STAFF TO THAT EFFECT IN WRITING.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I UNDERSTAND THAT I MAY RECEIVE A SEPARATE BILL IF MY MEDICAL CARE INCLUDES LAB, X-RAY, OR OTHER DIAGNOSTIC SERVICES. I FURTHER UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CO-PAY OR BALANCE DUE FOR THESE SERVICES IF THEY ARE NOT REIMBURSED BY MY INSURANCE FOR WHATEVER REASON.

CONSENT TO TREAT:

I HEREBY CONSENT TO EVALUATION, TESTING AND TREATMENT AS DIRECTED BY DR COLLEEN KENNEDY, MD OR HER/HIS DESIGNEE.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(IF DIFFERENT FROM PATIENT)

GUARANTOR NAME (PLEASE PRINT):_____

PATIENT NAME:_____DATE OF BIRTH:_____

HIPPA CONSENT

I GIVE THIS PRACTICE MY CONCENT TO USE MY PROTECTED HEALTH INFORMATION TO CARRY OUT MY TREATMENT, TO OBTAIN PAYMENT FROM INSURANCE COMPANIES, AND FOR HEALTH CARE OPERATIONS LIKE QUALITY REVIEWS.

I MAY REVIEW THE PRACTICE'S NOTICE OF PRIVACY PROCEDURES (FOR A MORE COMPLETE DESCRITION OF USES AND DISCLOSURES) BEFORE SIGNING THIS CONSENT.

I UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE THEIR PRIVACY PRACTICES AND THAT I MAY OBTAIN ANY REVISED NOTICES BY REQUEST FROM THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST A RESTRICTION OF HOW MAY PROTECTED HEALTH INFORMATION IS USED. HOWEVER, I ALSO UNDERSTAND THAT THE PRACTICE IS NOT REQUIRED TO AGREE TO THE REQUEST. IF THE PRACTICE AGREES TO MY REQUESTED RESTRICTION, THEY MUST FOLLOW THE RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, BY MAKING A REQUEST IN WRITING, EXCEPT FOR INFORMATION ALREADY USED OR DISCLOSED.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

RELATIONSHIP TO PATIENT:_____

THIS PAGE MUST BE READ AND SIGNED BY PATIENT

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS

AUTHORIZED RELEASE OF PROTECTED MEDICAL INFORMATION

From The Medical Office Of: _____
(This will be completed by your Pre-determination Coordinator based on the information provided in your paperwork.)

OFFICE PHONE #:_____ FAX #:_____

(Patient please complete your personal information completely and sign and date below)

Patient:_____ DOB:_____

Address:_____
City State Zip

(We will check the appropriate boxes based on your insurance requirements.)

___ Most recent History and Physical by the physician
___ Records regarding weight loss attempts documenting medications used, behavior modification, and exercise and includes the weight documented at each visit.
___ 1 chart note for each year shown below that documents patient's weight
_____ _____ _____ _____ _____

___ Documentation of co-morbid conditions and current treatment
___ Most recent EKG
___ Bariatric surgery operative note and all post-operative follow visits
___ Visit note to include a recommendation for bariatric surgery (required for insurance approval)
___ Other: _____

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

This authorization is effective unless revoked or terminated by the patient or the patient's representative.

X_____ _____
Signature of Patient **Signature of Patient Representative**

X_____ _____
Name of Patient (PRINTED) **Relationship of Representative to Patient**

Date:_____ **Date:**_____

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS

PHOTO CONSENT

Date: _____

I, _____ grant Kennedy Bariatrics and its representatives and employees the right to use my before and after photographs for medical and commercial purposes. I authorize Kennedy Bariatrics, it's assigns and transferees to use and publish the same in print and or electronically.

I agree that Kennedy Bariatrics may use such photographs of me with our without my name and for any lawful purpose, including publicity, illustration, advertising and web content.

I have read and understand the above.

Signature: _____

Printed Name: _____

Address: _____

_____

Kennedy Bariatrics

Colleen I. Kennedy, M.D., F.A.C.S., FASMBS

We may communicate with you by email in regard to your private health information. Due to the risk that electronic messages can be misdirected or intercepted by unintended parties, Kennedy Bariatrics cannot and does not guarantee the confidentiality of messages sent over the Internet. In addition, messages sent to or received from work email accounts also may be monitored or viewed by your employer. We do not believe that we should communicate private health information with you via e-mail unless you agree to do so, after you have considered these risks. If you wish to communicate by email, please respond by signing your consent below.

If you wish to communicate by e-mail, please respond by signing your consent below.

Patient Name Date

Email Address

Signature of Patient

Colleen I. Kennedy MD FACS FASMBS

Consent for Gastric Bypass Surgery

Name: _____

I authorize Colleen I. Kennedy MD to perform a Roux en Y Gastric Bypass on me for the treatment of clinically severe obesity.

I affirm that I am significantly overweight and have attempted medical weight loss without success. I acknowledge that the medical literature states that gastric bypass can improve or resolve many of the medical problems associated with obesity. However, I acknowledge that there is no guarantee to the degree of weight loss or improvement in co morbidities after my surgery.

I acknowledge that there are many options for surgical weight loss including but not limited to the gastric bypass, adjustable gastric band, sleeve gastrectomy and duodenal switch procedure. I have decided that the gastric bypass is my best option for surgical weight loss. I acknowledge my right to a second opinion.

The risks associated with gastric bypass surgery include but are not limited to:

Death: The risk of death after gastric bypass is reported at 0.5-1% in the medical literature.

Anastomotic leak: A leak from the staple lines created, the gastro-jejunostomy or jejunostomy is rare and reported at a rate of 1%. This may require reoperation.

Bleeding: The risk of bleeding requiring transfusion is reported at 2% after gastric bypass. This may require reoperation.

Deep Venous Thrombosis/ Pulmonary embolism: Blood clots that form in the legs or elsewhere and break off and travel to the lungs and heart are a significant cause of death after any major surgical procedure. My physician will do everything she believes possible to decrease the risk of formation of blood clots. It is my responsibility to contribute by ambulating as soon as possible after surgery. Despite all precautions it is impossible to eliminate the risk of blood clots entirely.

Prolonged Intubation and Ventilation

Heart Attack

_____

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Risks and Complications (continued)

Small bowel obstruction

Injury to esophagus, stomach, intestines, diaphragm, pancreas, spleen or liver

Infection – either at wound or intrabdominal (abscess)

Pneumonia

Nausea and Vomiting: This may be seen for many reasons. For the majority of patients this resolves within 48 hours of surgery. In rare cases nausea may persist for an extended period of time.

Food aversion

Anastomotic Stricture: This is seen in approximately 4-5% of patients. Most commonly this is seen at 4-8 weeks after surgery. However this can occur months to years after surgery. This is treated by endoscopic dilatation. Uncommonly a resistant stricture will require reoperation.

Ulcers: This is seen in 2-4% of patients. The risk of ulcers is increased in patients who use NSAIDs and ASA. Patients who smoke have a risk of ulcers at a rate of 10%. I agree to take an anti-acid medication after surgery for the rest of my life to decrease my risk of ulcer formation.

Hernias: Hernias are seen after gastric bypass in two locations. Port site or incisional hernias and internal hernias. These may be difficult to diagnose and I will contact a bariatric surgeon if I develop pain after surgery as non-bariatric surgeons may not recognize these hernias.

Gallstones: Significant weight loss is associated with gallstone formation. I agree to take preventive medication for 6 months after surgery to prevent against the formation of gallstones. I acknowledge that this medication will not eliminate the risk of gallstones and will only decrease it.

Failure to lose weight or regaining of weight loss: The gastric bypass is a powerful tool for weight loss, however it can be defeated. Eating high calorie snacks or "grazing" will result in less than expected weight loss or weight regain. The pouch or anastomosis may also be stretched by poor eating habits resulting in poor weight loss or weight regain. Despite compliance with all dietary and exercise programs post bypass, weight loss is not guaranteed and not all patients will reach expected goals.

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Vitamin deficiencies: The gastric bypass is a malabsorptive procedure. Vitamin supplementation is required after surgery. Many deficiencies have been reported including but not limited to: iron, vitamin D, calcium, vitamin B12, vitamin B1, niacin and folate. All patients are required to take a multivitamin, calcium, B12, B complex and iron after surgery. Sometimes additional supplements are required after evaluation of vitamin levels.

Hair loss: Hair loss occurs in many patients after surgery. Hair growth generally returns.

Depression: Some patients will have new occurrence of or worsening of depression secondary to gastric bypass surgery and changes experienced afterwards. It is my responsibility to seek psychological help when necessary.

Unforeseen complications: It is impossible to list every complication seen after surgery. I agree that my physician has done her reasonable best to list any significant complications that may occur.

Alternatives to surgical weight loss include: further attempts at medical weight loss attempts such as dietary modification, exercise, medication and behavior modification. The risk associated with these alternatives include: failure of weight loss, weight gain, worsening of co-morbid conditions and increased mortality secondary to morbid obesity.

I have read and understand the risks, benefits and alternatives to obesity surgery. I have discussed the above with my immediate family and have clearly stated to my family that I understand the risks of surgery and believe the risks are acceptable. I have had a chance to ask any questions that I may have had and all were answered to my satisfaction.

Signature:_____ Date/Time:_____

Printed Name:_____

Witness:_____ Date/Time:_____

Surgeon:_____ Date/Time:_____

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