Please complete and mail, fax, or e-mail to:
Meg El Haoud, RN
Bariatric Program Coordinator
788 8th Ave. SE
Level 3, Suite 300
Cedar Rapids, IA. 52401
Fax: (319) 398-6748 Phone: (319) 398-6747
melhaoud@mercycare.org

MERCY®
BARIATRIC SURGERY CLINIC

Full Name:_____Maiden Name:_____ Date:_____

Age:_____ _____Date of Birth:_____/_____/_____ Sex : MALE FEMALE

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

Mobile Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Email:_____SSN (Last 4 Digits):_____

Occupation:_____

Employer:_____

INSURANCE:

Primary Insurance:_____

ID#:_____Group#:_____

Policyholder (Subscriber Name):_____ Relationship:_____

Customer Service Phone Number:_____Subscriber Date of Birth:___/_____/_____

Secondary Insurance:_____

ID#:_____Group#:_____

Policyholder (Subscriber Name):_____ Relationship:_____

Customer Service Phone Number:_____Subscriber Date of Birth:___/_____/_____

Have you attended or are you registered for one of the mandatory bariatric surgery informational seminar?

YES NO

If yes, date attended:_____

EMERGENCY CONTACT:

Name:_____

Address: _____

Phone: (_____) _____ - _____ Relationship:_____

REFERRING PROVIDER:

Name:_____

Address:_____

Phone:_____ Fax:_____

PRIMARY CARE PROVIDER:

Name:_____

Address:_____

Phone:_____ Fax:_____

Name and addresses of other physicians you have seen in the past five years:

Specialty	Name	Address	Phone	Fax
Cardiologist:				
Pulmonologist:				
Endocrinologist:				
OBGYN:				

INSURANCE QUESTIONNAIRE: **Must Be Completed** **Date you called your Insurance:_____**

******We require that you call your insurance company so you fully understand your benefits and coverage******

1. Is bariatric surgery a covered benefit in my policy? YES NO

2. Is CPT code 43644 (Gastric bypass), 43770 (Adjustable Gastric Band, Lap Band), or 43775 (Sleeve Gastrectomy) a covered benefit? YES NO

3. (Only ask if you have previously had bariatric surgery) Is a revision surgery a covered benefit in my policy? YES NO

4. Is Dr. Sajida Ahad a covered specialist **(NPI# 1326024837)**? YES NO

4. Is Mercy Medical Center in Cedar Rapids, IA a covered facility? YES NO
   (**NPI# 1720029333**) 701 10th ST. SE- Cedar Rapids, IA 52403

5. What criteria must be met for approval?_____

6. Is a psychiatric evaluation for bariatric surgery a covered benefit? **(CPT codes 90791 – Psychological Diagnostic Evaluation & 96101 – Psychiatric Testing)** YES NO

7. Is nutrition consultation for bariatric surgery a covered benefit? **(CPT Codes 97802 – Medical Nutrition Therapy, Initial Assessment & CPT Code 97803 – Re-assessment and Intervention)** YES NO

8. If nutrition is a covered benefit, am I covered if I am seen by a Registered Dietitian? YES NO

9. Is the diagnosis of **Obesity E66.9 or Morbid Obesity E66.01** covered by my insurance plan if I see a registered dietitian? YES NO

10. How many visits do I need with a nutritionist/dietician prior to surgery?_____

11. How many visits do I need with a physician prior to surgery?_____

12. What is the length of time for physician supervised weight loss attempts prior to surgery as required by insurance company?_____

13. What is my deductible?_____What is my copay?_____

14. Does my insurance require bariatric surgery be performed at a Center of Excellence? YES NO

15. Does my insurance require bariatric surgery to be performed at a Blue Distinction Center? YES NO
    Mercy Medical Center isn't currently considered a Center of Excellence or a Blue Distinction Center at this time

16. Does my insurance cover a revision if I have previously had bariatric surgery? If yes, what is the criteria?_____

Insurance Representative Name:_____Reference Number:_____

PLEASE INCLUDE A PHOTO COPY OF YOUR INSURANCE CARDS (FRONT AND BACK)

What type of weight loss surgery are you interested?

1. Gastric Bypass (RNY, Roux-n-Y)
2. Adjustable Gastric Band (Lap Band)
3. Sleeve Gastrectomy (Sleeve)
4. Revision surgery:

   What type of bariatric surgery did you have previously?_____

   When was your previous surgery performed?_____

   Where was your previous bariatric surgery performed?_____

   Reason for seeking revision?_____

5. Unsure

WEIGHT HISTORY:

My obesity started (fill in the circle next to the most appropriate response):

In childhood At puberty As an adult After pregnancy After a traumatic event

Other (please specify):_____

Highest adult weight:_____At what age?_____

Lowest adult weight:_____At what age?_____

Most weight lost on any program:_____Program type/name:_____

Current weight in pounds:_____BMI:_____

Current height in Feet:_____Inches:_____

How did you hear of our program? (Circle the appropriate response)

Web TV Radio Doctor Referral Friend

Patient Seminar Mercy Employee Other (please specify):_____

SOCIAL HISTORY:

Do you currently smoke or use any other form of tobacco? YES NO

If yes, how much or how often do you smoke or use tobacco?_____

How long have you smoked or used tobacco?_____

Have you ever PREVIOUSLY smoked or used tobacco? YES NO

If yes, how much or how often did you smoke or use tobacco?_____

How long ago did you quit?_____

Do you consume alcohol? YES NO

If yes, how much alcohol do you consume?_____

What type of drink do you consume?_____

Have you ever received treatment for alcohol use? YES NO

If yes, what year and for how long?_____

Do you use any other recreational drugs? YES NO

If yes, what do use and how often?_____

Have you ever received treatment for drug use? YES NO

If yes, what year and for how long?_____

MEDICAL HISTORY- Please X all the appropriate conditions or co-morbidities:

Condition	Check if you have had this or do now	Past or Now	Name of Medication/Treatment	Dosage and Frequency
High blood pressure (hypertension)				
Diabetes				
Sleep apnea				
Daytime sleepiness				
Snoring				
Heartburn				
GERD				
Heart disease				
COPD				
High cholesterol				
Joint pain				
Back pain				
Hip pain				
Knee pain				
Ankle/foot pain				
Swelling of feet				
Urinary incontinence (stress or urge)				
Blood clots				
Deep vein thrombosis (DVT)				
Pulmonary embolism (PE)				
Stroke				
Shortness of breath				
Asthma				
Emphysema				
Headaches				
Migraines				
Kidney disease				
Seizures				
Arthritis				
Cancer				
Rashes				
Irregular periods				
Fatty liver				
Other (please specify):				

PSYCHIATRIC HISTORY:

Condition	Name of Medication/Treatment	Hospitalized	Dates
Depression			
Severe Depression			
Schizophrenia			
Bipolar			
Anorexia			
Bulimia			
Other (please specify):			

Do you currently see a mental health professional (psychiatrist, psychologist, therapist, counselor)? YES NO

If YES, for what? _____

Name of Facility:_____ Name of Mental Health Professional:_____

SURGICAL HISTORY- Please list any other surgery **not listed** here on the back of this page:

Procedure	Date	Open or Laparoscopic
Tubal Ligation		
Tonsillectomy		
Appendectomy		
Hysterectomy		
Back Surgery		
Heart Bypass (CABG)		
Arthroscopy		
Intestine Surgery		
Joint Replacement		
Cholecystectomy (gallbladder removal		
Caesarean Section	**Yes** ○ **No** ○	
Total Hysterectomy		
Abdominal Hernia Repair		

Have you ever had any trouble with anesthesia? YES NO If yes, what?_____

PREGNANCY HISTORY (Please list any additional pregnancies on the back of this page):

Pregnancy	Year	Weight at start	Weight at delivery

Current method of birth control:_____

DRUG ALLERGIES (If none- leave blank. Please list any additional allergies on the back of this form.):

Drug	Reaction

FAMILY HISTORY – (Please X all appropriate boxes):

Family Member	Obesity	Diabetes	High blood pressure	Heart Disease	Cancer (what type)
Father					
Paternal grandfather					
Paternal grandmother					
Father's brothers					
Father's sisters					
Mother					
Maternal grandfather					
Maternal grandmother					
Mother's brothers					
Mother's sisters					
Your brother(s)					
Your sister(s)					
Your son(s)					
Your daughter(s)					

EXERCISE HISTORY:

Are you able to exercise? YES NO

If yes, what type of exercise:_____

How often and for how long do you exercise?_____

If you are unable to exercise, is it due to: SEVERE JOINT PAIN SHORTNESS OF BREATH

OTHER: _____

EATING PATTERNS/HABITS:

Counting all meals and any snacks you may have during the day, how many times a day do you usually eat?

_____ What times a day?:_____

How many days a week do you eat out?_____

Breakfast_____days a week_____

Brunch/Lunch _____days a week_____

Dinner/Supper _____days a week_____

In the past 6 months, have you experienced any food craving (such as intense desires to eat a certain food)?

YES NO

During the past 6 months, did you ever eat what most people, such as your friends/family, would think was a very large amount of food? YES NO

Did you ever eat a very large amount of within a short time such as 2 hours or less? YES NO

WEIGHT LOSS DIET HISTORY:

Complete the table below listing all food or liquid diets you have tried in an attempt to lose weight. This information is very important to complete in its entirety so that you may be eligible for insurance coverage for surgery. Provided below is only a sample list of some diets.

Reminder: List all of the diets you previously tried.

Name of diet:	Year:	How long were you on the diet? (Years/months)	Number of pounds lost:	Was this under a doctor's supervision?
Atkins				
Biggest Loser				
Cabbage Soup				
Low Calorie				
Grapefruit				
Jenny Craig				
Ideal Protein				
Slim Fast				
Weight Watchers				
Mayo Clinic				
Medifast				
Optifast				
Mediterranean				
South Beach				
Paleo				
TOPS				
Nutri-System				
Metabolite				
Dietician Consult				
Hypnosis				
Other (please specify)				

WEIGHT LOSS MEDICATION HISTORY- (if you have not used any weight loss medications, please skip to the next section):

Medication	Physician who prescribed	Year taken	Amount of weight lost in pounds	How long did you take medications (months/years)	Reason stopped (see list below)
Phentermine					
Diethylpropion					
Ephedrine					
Sibutramine					
Orlistat					
Phendimetrazine					
Topiramate					
Pindolol					
5HTP & Carbidopa					
Spironalactone					
Fluoxetine & Sertraline					
Bupropion					
Zonisamide					
Metformin					
Exenatide					
Liraglutide					
Pramlintide					
Naltrexone & Bupropione					
Zonisamide & Bupropion					
Topiramate & Phentermine					
Rimonabant					
Other (name of medication)					

Reason medication was stopped:

1. Anxiety
2. Rapid heart rate
3. High blood pressure
4. Valvular heart disease
5. Pulmonary hypertension
6. Lack of results
7. Diarrhea
8. Mood changes
9. Pregnancy
10. Cost
11. Dry Mouth
12. Other (please specify)

TYPICAL DIET:

Please fill this in as honestly as possible for a *TYPICAL* week and weekend day. Include amount consumed, way food was prepared (steamed, fried, baked, raw, etc.), and beverages.

Meal	***Weekday* Day**	***Weekend* Day**
Breakfast		
Lunch		
Dinner/Supper		
Snack 1		
Snack 2		
Snack 3		

MEDICATIONS- Please list all medications you take including herbal and over-the-counter:

Name of medication	Dosage	Frequency	Reason for taking	How long have you been taking?

Epworth Sleepiness Scale:

For the following, ask yourself; how likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation Chance of Dozing (0-3)

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. a theatre or a meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in the traffic _____

FOR OFFICE USE ONLY:

Score:	Reviewed by:	Date: