Rex Bariatric Specialist

NUTRITIONAL AND DIET EVALUATION

A. Weight/Dieting History:

1. List your approximate weight in pounds at the following ages?

   10 y/o ____ lbs, 20 y _____ lbs, 30 y _____lbs, 40 y ____ lbs, 50 y ____ lbs, 60 _____ lbs

2. Please list your heaviest weight, (exclude pregnancies) _____ lbs _____ age.

3. Have you tried weight loss through structured dieting or other treatment? ☐ Yes ☐ No

4. If yes, list all food/ liquid diets or treatments attempted. Many insurance carriers require this information; therefore, please provide an accurate and complete listing.

Diets:			**Behavioral Treatments:**
Atkins/Low Carb	Nutri-system	TOPS	Diet Counseling
Grapefruit	Optifast/Medifast	Weight Watchers	Hypnosis
Jenny Craig	Physicians Weight Loss	Volumetrics	Personal physician
Liquid Protein	Slimfast	Zone Diet	Residential Diet Center
Metabo-life	South Beach Diet		Exercise Trainer

Name of Diet/Treatment	**Lbs. Lost**	**Physician directed?**

5. List all medications used by you for weight loss. Listed below are the most common medications. Please provide an accurate and complete list of any medications used in the past: Acutrim, Alli, Bontril, Didrex, Phentermine, Xenical, Dexatrim, Fen/Phen, Meridia, Redux.

Medication & Dose	**Start year**	**Length (Mos.)**	**Lbs. Lost**	**Physician directed**

NUTRITIONAL PRE-SCREENING ASSESSMENT

B. Diet Behavior

1. Current challenges to improving my health include:
    a. Lack of time
    b. Lack of motivation
    c. Work Schedule
    d. Too expensive Social Calendar
    d. Family responsibility
    e. Illness or physical limitation
    f. Other

2. My hidden sources of extra calories most likely come from:
    a. Large portions
    b. Soda/other beverages
    c. Sweets
    d. Chips
    e. Fried foods
    f. Eating when bored/upset/stressed (not hungry)
    g. Eating while cooking
    h. Going out to eat
    i. Eating while watching television
    j. None identified
    k. Other: _____

3. How do you feel about making behavioral changes?
    a. Ready to start making changes now
    b. Ready to think about making changes
    c. Not ready to make any changes to my current lifestyle

4. How many days a week do you eat breakfast?
    a. 1 day
    b. 2-3 days
    c. 3-5 days
    d. 5-7 days

5. How often do you eat between meals?
    a. Seldom
    b. 1 time per day
    c. 2 time per day

6. What is your usual pattern for the evening meal?
    a. Seldom eat dinner
    b. Lightest meal
    c. Moderate meal
    d. Largest meal

7. Which sources of protein do you eat most often?
    a. Red meat
    b. Fish and Chicken
    c. Eggs and Dairy
    d. Tofu, beans, and lentils

8. I eat appropriate portion sizes:
    a. I don't know
    b. Rarely
    c. Sometimes
    d. Often

9. I eat fruits and vegetables.
    a. No, I do not.
    b. With cheese, butter, or dressing
    c. Canned
    d. Fresh or frozen

NUTRITIONAL PRE-SCREENING ASSESSMENT

10. Which types of carbohydrates do you choose most often:
    a. I avoid carbs
    b. Whole grains
    c. White/refined carbs
    d. Sweets

11. How often do you eat low-fat dairy products?
    a. Seldom
    b. 1-2 times per week
    c. 1 time per day
    d. 2 times per day

12. Which types of drinks do you choose most often?
    a. Water
    b. Flavored water and diet soda
    c. Fruit juice
    d. Sweet tea or regular soda

13. How much alcohol do you consume?
    a. 1-2 times per week
    b. 1 time per day
    c. 2 or more time per day
    d. None

14. Does your work or daily activity primarily include the following:
    a. Sitting
    b. Standing
    c. Walking or moderate lifting
    d. Heavy manual labor

15. How often do you exercise for 20 minutes or more each week?
    a. Seldom
    b. 1-2 times per week
    c. 3-4 times per week
    d. Daily

16. How many hours of sleep do you typically get a night?
    a. 1-2 hours
    b. 3-4 hours
    c. 5-6 hours
    d. 7 or more hours.

REX BARIATRIC SPECIALISTS

Referring Physician: _____

NAME_____ **Chart#**_____ **DOB**_____

Social History/ Demographics

Race	☐ African American ☐Asian☐ Caucasian ☐Hispanic ☐Native American ☐Other ☐Pacific Islander/Hawaiian
Gender	☐Male ☐Female
Employ	☐ Full Time ☐ Part Time ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed ☐ Not Specified
Marital	☐ Single ☐ Married ☐ Divorced ☐Other
Insured	☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other Government Insurance ☐ Self Pay

Past Surgical History

Previous Bariatric Surgery	Year/Original Weight/Lowest Weight Achieved/Surgeon/Complications
Other Surgery	

Past Medical History

Please check all medical problems you have had in the past: ☐ **NONE**

Cardiovascular
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Ischemic Heart Disease
- ☐ Angina
- ☐ Peripheral Vascular Disease
- ☐ Lower Extremity Edema
- ☐ DVT/PE (Clots)
- ☐ Atrial Fibrillation

Metabolic
- ☐ Diabetes (Glucose Metabolism)
- ☐ Lipids/ Hyperlipidemia
- ☐ Gout/ Hyperuricemia

Pulmonary
- ☐ Obstructive Sleep Apnea
- ☐ Obesity/Hyperventilation
- ☐ Pulmonary Hypertension
- ☐ Asthma
- ☐ COPD

Gastrointestinal
- ☐ GERD (reflux)
- ☐ Cholelithiasis (gallbladder)
- ☐ Liver Disease
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Inflammatory Bowel
- ☐ Gastric ulcer

Musculoskeletal
- ☐ Back Pain
- ☐ Musculoskeletal (Joint)
- ☐ Fibromyalgia

Reproductive
- ☐ Polycystic Ovary Disease
- ☐ Menstrual Irregularity
- ☐ Infertility

Psychosocial
- ☐ Mental Health Diagnosis
- ☐ Depression
- ☐ Psychosocial Impairment
- ☐ Alcohol Use
- ☐ Substance Abuse
- ☐ Tobacco Use

General
- ☐ Stress Incontinence (urine)
- ☐ Pseudotumor Cerebri
- ☐ Abdominal Hernia
- ☐ Functional Impairment
- ☐ Abdominal Skin/Pannus

Endocrine:
- ☐ Hyperthyroid
- ☐ Adrenal disorder

Renal:
- ☐ Renal Failure
- ☐ Kidney Stones

Neurologic
- ☐ Stroke or TIA
- ☐ Muscle Weakness
- ☐ Alzheimer's

Immunity
- ☐ HIV/AIDS
- ☐ Bleeding Disorder
- ☐ Clotting Disorder
- ☐ Lupus
- ☐ Autoimmune Disease

Cancer (list type)

_____
_____
_____
_____

Family Medical History

	Relationship
Diabetes	
Hypertension	
Breast Cancer	
Colon Cancer	
Heart Disease	
Other:	

NAME_____ **Chart #** _____ **Date of Birth**_____

Please List Any Allergies and Reaction:	**Latex Allergy** ☐

Medications: Please list all prescription and over the counter medications you are taking:

Pharmacy Name _____ **Phone Number** _____

Name	**Dose**	**Prescribed for:**	**Name**	**Dose**	**Prescribed for:**

Are You Currently Experiencing any of the Following Symptoms?

Constitutional		Y/ N	Palpitations	**Genitourinary**		**Neurological**	
Y/ N	Weight gain	Y/ N	Calf or foot pain	Y/ N	Painful Urination	Y/ N	Numbness
Y/ N	Fever	Y/ N	Lower leg swelling	Y/ N	Bloody Urine	Y/ N	Confusion
Y/ N	Night sweats	**Respiratory**		**Musculoskeletal**		Y/ N	Convulsions
Y/ N	Chills	Y/ N	Shortness of breath	Y/ N	Joint Pain	Y/ N	Tingling hands/Feet
Y/ N	Loss of appetite	Y/ N	Wheezing	Y/ N	Joint Swelling	Y/ N	Restless legs
Y/ N	Fatigue	Y/ N	Chronic Cough	Y/ N	Joint Stiffness	Y/ N	Limb Weakness
Eyes		Y/ N	Coughing Blood	Y/ N	Limb Pain	Y/ N	Difficulty Walking
Y/ N	Visual impairment	**Gastrointestinal**		**Integumentary**		**Psychological**	
Y/ N	Blind spot	Y/ N	Abdominal Pain	Y/ N	Skin Lesion	Y/ N	Addiction
ENT		Y/ N	Nausea	Y/ N	Skin Wound	Y/ N	Anxiety
Y/ N	Trouble Swallowing	Y/ N	Vomiting	Y/ N	Jaundice (Yellow Skin)	**Endocrine**	
Y/ N	Hearing loss	Y/ N	Heartburn	Y/ N	Infections	Y/ N	Hot Flashes
Y/ N	Hoarseness	Y/ N	Constipation	Y/ N	Rash	Y/ N	Muscle Weakness
Y/ N	Snoring	Y/ N	Diarrhea	**Breast**		Y/ N	Deepening of voice
Cardiovascular		Y/ N	Change in Stools	Y/ N	Breast Tenderness	**Heme/Lymph**	
Y/ N	Rapid Heart Rate	Y/ N	Black/Tarry Stools	Y/ N	Breast Discharge	Y/ N	Easy Bleeding
Y/ N	Chest Pain at Rest	Y/ N	Rectal Bleeding	Y/ N	Palpable Breast lump	Y/ N	Bruising
Y/ N	Chest Pain w/ activity	Y/ N	Hemorrhoids	Y/ N	Ski Changes	Y/ N	Swollen Glands

Other_____
_____

I Certify the above to be accurate _____ Date: _____ Time: _____

Review by: _____ Date: _____ Time: _____

UNDERSTANDING YOUR HEALTH INSURANCE/ WEIGHT LOSS SURGERY BENEFITS

Weight loss surgery (Gastric bypass, Sleeve Gastrectomy, and Lap Band) is an elective surgical procedure and not all insurance plans include coverage. To understand your insurance coverage, use the following worksheet to guide you through the inquiry process and help accurately determine your current insurance plan.

Please use the questions as listed below when speaking with your insurance carrier. This language allows your carrier representative to best understand your question and explain the details of your benefits.

We also ask that you attach **a copy of your insurance card** (both front and back) to your packet. We contact your carrier separately to confirm your benefit coverage for weight loss surgery.

Phone Tips: Some patients encounter customer service representatives who misinterpret your call as an attempt to obtain authorization for your surgery. Please make clear to the customer service representative that you are calling **for explanation and clarification of your plan benefits**, and **not** asking to be pre-certified or pre-authorized for bariatric or weight loss surgery. If you still feel unclear about your benefits after speaking to a representative, politely ask to speak to the supervisor.

What if Morbid Obesity Related Surgery is listed as an exclusion in your insurance plan? From the standpoint of both your insurance carrier and employer, surgical coverage often differs between obesity surgery and other surgery, such as coronary artery bypass, fracture repair, appendectomy, or a mastectomy. Specifically, some insurance contracts list obesity surgical options as plan exclusions (i.e. not covered).

Insurance exclusions, however, do not indicate the medically necessity of obesity surgery. Instead, the exclusion simply means that your employer elected against including this service as a covered benefit in your plan. This is similar to other exclusions for cosmetic surgery, infertility services, and Lasik vision correction. If you encounter a morbid obesity exclusion in your plan, meet with your Human Resources Department to discuss the possibility of changing your plan benefits. You might also explore appealing for special consideration on an individual case basis through your employer and insurance company.

HEALTH INSURANCE INFORMATION QUESTIONAIRE
Please complete each question as thoroughly as possible.

Insurance Company Name: _____

Member Customer Service Phone #: _____

Date Contacted: _____

Person spoken to: _____

1. Hello, my name is _____, and I would like to learn about my plan benefits with regard to morbid obesity surgery, such as gastric bypass and lap banding. Does my policy cover services related to morbid obesity or is it an "exclusion" of my contract?

   ☐ Coverage ☐ Exclusion
   If it s an "exclusion", the rest of the questions will not be applicable.

2. Is a referral necessary to be seen by a Bariatric Surgeon? ☐ Yes ☐ No

2. Does my policy cover services for any related surgery clearances such as cardiac, pulmonary, nutritional, and psychological evaluations and Pre-Admission Testing?
☐ Yes ☐ No

3. If benefits are allowed, what are the Medical Policy requirements? How can I obtain a copy of them for review? (Is it available on internet or can one be mailed to me?)

- Is Center of Excellence (COE) required? ☐ Yes ☐ No
- BMI minimum: _____
- Diet history: _____ months within the past _____ months.
- Exercise history: _____ months within the past _____ months.
- Weight history: _____ years overweight (Do not confuse with a "diet" history)
- Does my policy cover services for dietary/nutritional consults?
- Any additional requirements: ☐ Yes ☐ No
  (If yes, explain on separately attached form.)

5. At what level does my policy pay for the following services (i.e.; 100%, 80%)?

% of Payment	CPT CODE	DIAGNOSIS CODE
_____	99244 Office Consultation	278.01
_____	43846 Gastric Bypass – Open	278.01
_____	43644 Gastric Bypass – Laparoscopy	278.01
_____	43770 Laparoscopy, gastric band	278.01

6. Do I have a deductible that must be satisfied? If so, how much? $_____

7. What is my office visit co-pay amount?
_____

8. Following surgery, periodic office visits are required after the 90 day global period and at minimum annually. Are these office visits a covered benefit? Will they be covered when I am no longer diagnosed as morbidly obese? ☐ Yes ☐ No

9. I will also need periodic lab work done following my surgery, and at minimum, at least annually. Will these services by covered? Will they be covered when I am no longer diagnosed as morbidly obese? ☐ Yes ☐ No

9. Attach a copy of your insurance card (front and back) to this form:

_____
Patient Name (printed) Social Security Number

_____
Patient Signature Date

Return completed form to:
Rex Bariatric Specialist
Krista Herrell, Bariatric Navigator
2800 Blue Ridge Road
Raleigh, NC 27607
Phone: 919-784-7874
Fax: 919-784-2801