

# ***STEPS to Weight Loss Surgery***

Congratulations on your decision to pursue weight loss surgery. We are grateful that you have chosen Carolina Surgical to help you along your journey. Before doing anything else, please first call your health insurance company to make sure they cover bariatric surgery. Ask the following question:

- Does my policy cover weight loss surgery when medically necessary?

You do not want to get too far along in the process without being sure you have insurance coverage.

Our comprehensive program is a nationally recognized Center of Excellence in Bariatric Surgery. It includes experienced bariatric surgeons, dedicated nurses, nutritional support, clinical coordinators, and a compassionate support staff. To maintain the level of excellence that you deserve, there is a \$250.00 Non-Refundable Administrative Program Fee. The fee does not cover any of your insurance co-payments or deductibles, and payment is mandatory at your first appointment.

**This packet will take you through the 3 simple steps to getting your surgery:**

- STEP 1      Get medical records of your weight for the last 2 years
- STEP 2      Psychological evaluation
- STEP 3      Weight management program

**Please print this entire document and  
bring it with you to your first office appointment.**

# **STEP 1**

## **Get Medical Records**

Weight loss surgery is a last resort option for people who have been struggling with obesity for years. Insurance companies want to see proof that you have struggled with your weight for at least 2 years. Complete this Records Release form and give it to your primary care doctor.

I hereby authorize you to release my medical records to Carolina Surgical.  
Please provide:

- Office notes that document my weight for the last 2 years.
- I cannot accept a table that simply lists my weight. I must demonstrate my weight in a provider's note.

Please fax to 704-409-2077

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

## **STEP 2**

### **Psychological Evaluation**

All patients must have a psychological evaluation before weight loss surgery.

In **Step 2**, please make an appointment with either a Psychiatrist or Psychologist for your evaluation. You may find your own doctor or call one from our recommended list. Please have the evaluation faxed to 704-409-2077.

Lisa Lorence, Psy.D 6201 Fairview Rd. Charlotte, NC 28210	704-372-0670
Sara Rose, Ph.D, LPC 1515 Mockingbird Ln., Suite 800 Charlotte, NC 28209	704-525-1213
Corinne Goodwin, PhD 1801 East 5th St., Suite 110 Charlotte, NC 28204 csgphd.com	300 E John St., Suite 138 Matthews, NC 28105 704-221-3172
J.W. Scott Wallace, MD 3303 Latrobe Dr. Charlotte, NC 28211	704-362-2663
Erin Taylor, Ph.D 3303 Latrobe Dr. Charlotte, NC 28211	704-945-2201
Michele Kerbow, MD 2555 Court Dr. Gastonia, NC 28754	704-865-3848
Rose LeDay, Ph.D 3111 Monroe Rd, Suite 100 Charlotte, NC 28205	704-927-5885
Charles Schmittiel, PhD 380 Copperfield Blvd. Concord, NC 28025	704-403-1800

## **STEP 3**

# ***Weight Management Program***

In order to get the most out of your surgery, you must make a lifelong commitment to healthy eating and exercise. We offer a comprehensive medical weight loss program that teaches you how to eat differently and live a more active lifestyle. Participation in the program is mandatory and it will continue to be available to you even after your surgery. The program includes:

- A 40 minute, one-on-one initial evaluation with our registered dietician to assess your current eating and exercise habits, and give you a personalized plan
- Monthly visits with the dietician to check your progress for 12 months
- Food log tracking
- Behavior modification
- Exercise counseling
- Support groups
- Private monthly weigh-ins
- Accountability on a regular basis

Some insurance companies require that you participate in this program for 3 - 6 months before approving you for surgery, but others don't so be sure to check on your specific requirements. For your convenience our website offers the specific requirements of some selected insurance companies.

There is no additional fee for our Weight Management Program and it is good for 12 months of service.

# ***Preparing for Surgery***

As you complete your steps to surgery, we will keep you updated along the way. Simply visit our website at any time to find out your status.

Once the 3 steps have been completed, we will submit all of your information to your insurance company for approval. Most companies take 1-2 weeks to reply. This is a good time to double-check your deductible, since that will be due before your surgery can be scheduled. Once your insurance approves your surgery, we will schedule a date and time that works for you.

Well, your journey has begun. We are excited to travel along with you, and we thank you again for choosing Carolina Surgical.

**Please fill out the following registration forms and bring them with you to your first office visit.**

# ***Learn More About Weight Loss Surgery***

Carolinasurgical.com

Obesityhelp.com

Realizeband.com

Lapband.com

## ***Frequently Asked Questions***

### **How long will it take me to have my surgery?**

It can take anywhere from 1 – 7 months. It all depends on what your insurance company requires of you before your surgery, and how long it takes you to complete the 4 steps. If your insurance does not require a physician supervised, pre-operative weight loss program, and you complete your 4 steps quickly, you could have your surgery as soon as one month.

### **How much weight will I lose?**

That is really up to you. On average, patients can lose between 60-160 lbs in the first year after weight loss surgery. How much weight you lose depends on your excess weight before surgery, and how well you exercise and eat properly after surgery. If you do not exercise and do not change your eating habits after surgery, you will lose less weight. If you walk at least 40 minutes per day for exercise, and follow the nutritionist's instructions on eating properly, you will lose more weight.

### **How much will the surgery cost?**

Your out of pocket cost will be your deductible for surgery and your co-pays. You will have to ask your insurance company what your deductible is. Payment of your deductible is required before surgery can be scheduled.

### **Will I have excess skin after the weight loss?**

You most likely will, but it is impossible to predict how much you will have. If you ever choose plastic surgery for excess skin, you should wait for at least 2 years from the time of your weight loss surgery. Insurance will generally not pay for plastic surgery.

# Bariatric Initial Visit

Date \_\_\_\_\_

Name \_\_\_\_\_ Referring Physician \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Personal Physician \_\_\_\_\_

## PAST MEDICAL HISTORY

a. How many years have you struggled with obesity? \_\_\_\_\_

b. List prior diets or weight loss programs:

Name of diet or weight loss program	Year you did the diet or weight loss program	Time spent in the diet or program	Maximum weight loss achieved in the program

c. List any current or past medical conditions (high blood pressure, diabetes, heart problems, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d. List previous operations and approximate dates \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES TO MEDICATIONS** \_\_\_\_\_

## CURRENT MEDICATIONS

Name of medication

dosage

times per day

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If you smoked in the past, when did you quit? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ If yes, how much and how often? \_\_\_\_\_

## FAMILY HISTORY

Do any of the following run in your family: (circle)

Heart disease    Diabetes    Cancer    Bleeding disorder    Other diseases \_\_\_\_\_

## SOCIAL HISTORY

Marital status    M    S    D    W    Number of children \_\_\_\_\_    Occupation \_\_\_\_\_

# **Bariatric Initial Visit**

Do you have any of the following?

**YES    NO**

**GENERAL**

- Recent weight change
- Fever
- Excessive fatigue

**EYES**

- Blindness
- Double vision
- Blurry vision

**EARS, NOSE, MOUTH**

- Decreased hearing
- Ringing in ears
- Sores of mouth or tongue
- Difficulty Swallowing

**CARDIOVASCULAR**

- Chest Pain
- Shortness of breath
- Palpitations or skipped heart beats
- Previous heart attack
- Congestive heart failure
- Ankle swelling

**RESPIRATORY**

- Cough
- Asthma
- Emphysema

**GASTROINTESTINAL**

- Nausea or vomiting
- Diarrhea
- Constipation
- Blood in stool
- Hiatal hernia
- Ulcer disease
- Jaundice
- Hepatitis

**GENITOURINARY**

- Kidney stones
- Burning with urination
- Blood in urine
- Incontinence
- Difficulty with urination

**MUSCULOSKELETAL**

- Muscle weakness
- Joint pain
- Arthritis

**YES    NO**

**SKIN**

- Rash
- Boils or sores

**BREAST**

- Mass or lump
- Discharge
- Pain

**NEUROLOGICAL**

- Stroke or paralysis
- Seizures
- Dizziness or fainting

**PSYCHIATRIC**

- Anxiety attacks
- Depression
- Nervous breakdown

**ENDOCRINE**

- Lump or mass in neck
- Thyroid problems
- Other glandular problems

**HEMATOLOGIC**

- Easy bruising or bleeding
- Anemia
- Swollen lymph nodes
- Sickle cell trait

**IMMUNOLOGIC**

- Hay fever
- HIV or AIDS

Do you have any other medical condition

Not covered in this questionnaire?

Explain:

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Completed by \_\_\_\_\_

\_\_\_\_\_ Date

# Nutrition Initial Visit

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

Family Weight History: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

What was your highest/lowest adult weight? \_\_\_\_\_

In your opinion, what has caused your weight gain over the years?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Portion Sizes    | <input type="checkbox"/> Eating too much fat/sugar                | <input type="checkbox"/> Stress         |
| <input type="checkbox"/> Lack of Exercise | <input type="checkbox"/> Compulsive eating                        | <input type="checkbox"/> Genetics       |
| <input type="checkbox"/> Emotional Eating | <input type="checkbox"/> Lack of knowledge about healthful eating | <input type="checkbox"/> Nervous Eating |

How many times per week do you eat out and where? \_\_\_\_\_

How much water and other beverages do you drink daily? \_\_\_\_\_

Do you get any regular exercise or activity? Yes or No

What kind? \_\_\_\_\_ How often? \_\_\_\_\_

Who (of friends and family) is most supportive of you having this surgery? \_\_\_\_\_

## DIET HISTORY: (Recall a Typical Day)

Breakfast                      snack                      Lunch                      snack                      Supper                      snack

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### Office use only:

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations and Patient Instructions:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Keep a food log               | <input type="checkbox"/> Keep calories < _____ / day       | <input type="checkbox"/> No snacks             |
| <input type="checkbox"/> Collect Labels                | <input type="checkbox"/> Decrease fried foods              | <input type="checkbox"/> No soda               |
| <input type="checkbox"/> Decrease fat and sugar intake | <input type="checkbox"/> Exercise 30 - 60 minutes each day | <input type="checkbox"/> Avoid TV while eating |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Registered Dietitian \_\_\_\_\_

Date \_\_\_\_\_

# Registration Form

Account # \_\_\_\_\_ Date \_\_\_\_\_

Patient's Full Legal Name \_\_\_\_\_  
Last First Middle Maiden Preferred Name

Patient's Address \_\_\_\_\_  
Street City State Zip Code

Home Phone ( ) \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

Cell Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_  Married  Single  Divorced  Widowed

Patient's Employer \_\_\_\_\_  
Position Bus. Phone

Spouse / Next of Kin Full Name \_\_\_\_\_  
Last First Middle Maiden

Spouse / Next of Kin Employer \_\_\_\_\_  
Position Bus. Phone

Relative, or close friend, not living with Patient \_\_\_\_\_  
Relationship to Patient Phone

Referring (Doctor) (Person) \_\_\_\_\_  
Name Phone Number

Personal or Family Physician \_\_\_\_\_  
Name Phone Number

Have you ever been a patient in our office before?  Yes  No When? \_\_\_\_\_

## Below is for Office Use Only:

**First Insurance Company:**  Medicare  Medicaid  BlueCross/BlueShield  Worker'sComp  Copay \_\_\_\_\_  
 Other (Name & Address) \_\_\_\_\_

Policy # / SS# \_\_\_\_\_ Group Name / # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_  Self  Spouse  Child  Other  
Relationship of Patient to Subscriber

Subscriber's Date of Birth \_\_\_\_\_

**Second Insurance Company:**  Medicare  Medicaid  BlueCross/BlueShield  Worker'sComp  Copay \_\_\_\_\_  
 Other (Name & Address) \_\_\_\_\_

Policy # / SS# \_\_\_\_\_ Group Name / # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_  Self  Spouse  Child  Other  
Relationship of Patient to Subscriber

Subscriber's Date of Birth \_\_\_\_\_