THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

BARIATRIC SURGERY PROGRAM APPLICATION

Instructions: 1) Type directly on form or print out and handwrite. 2) Save form and/or print a copy for your records. 3) Email saved form to: **ObesitySurgery@osumc.edu** or mail/drop off a copy to **Ohio State Martha Morehouse Outpatient Care, Bariatric Surgery, 2050 Kenny Rd, Concourse Suite 1222, Columbus OH, 43221**.

Date:							
SELF							
Last Name:		First:		MI:		Maiden:	
Address:							
City:		State:		Zip:			
Contact #:		Height:		Weight:			
Date of Birth:		Email:					
Gender at Birth	☐ Male ☐ Female						
Race:	☐ White ☐ Hispanic	☐ Asian	☐ Native American / Alaskan Native				
	☐ African American	☐ Other:					
Employer							
YOUR PRIMARY CARE PROVIDER							
Provider Name:							
City:		State:		Zip:			
Phone:		Fax:					

If you don't have a primary care provider, you must be established or scheduled with one prior to your first visit.

PRIMARY INSURANCE INFORMATION					
Primary Insurance Co:					
Address:					
City:		State:		Zip:	
Policy Holder's Name:					
Relationship to Patient:					
Policy #:		Group / Plan #:			
Customer Service Phone:					
Provider Inquire / Pre-Certification Phone:					
Contact Person:					
Is weight loss surgery for "Morbid Obesity" a covered benefit?			☐ Yes	☐ No	
If you have **EVER** had weight loss surgery: Is **REVISION SURGERY** a covered benefit:			☐ Yes	☐ No	

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third-party carriers and request payment to be made directly to the billing entity.

I understand that I am financially responsible for any balance not covered by the insurance carrier(s).

I also request that payment of benefits from my policy _____ (Medigap/other) be paid directly to the billing entity until otherwise notified.

Signature: _____

Signature of Parent (if minor): _____

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MEDICAL HISTORY

1.	Have you had any prior weight loss surgeries or procedures **OR** started the process for bariatric or weight loss surgery in the past? (i.e. Roux-en-Y gastric bypass, sleeve gastrectomy, duodenal switch, gastric banding, vertical banded gastroplasty, endoscopic weight loss procedures, intragastric balloon, etc).		YES	NO
2.	Has your weight changed more than 10 lbs. in the last five years?		YES	NO
3.	Do you have a primary care provider (i.e. family doctor, PA or NP)?		YES	NO
4.	Are you currently using tobacco or nicotine? (i.e. cigarettes, cigars, hooka, vapes, e-cigarettes, nicotine replacement products, etc.)		YES	NO
5.	Have you ever been seen in the emergency department or admitted to a hospital/treatment facility for any of the following:			
	Mental health crisis		YES	NO
	Alcohol intoxication/overdose		YES	NO
	Drug intoxication/overdose		YES	NO
	Disordered eating (i.e. binge eating, anorexia, etc).		YES	NO
6.	Have you been diagnosed or treated for cancer within the last five years?		YES	NO
7.	Have you had a sleep study?		YES	NO
8.	Do you have sleep apnea?		YES	NO
9.	Do you use oxygen?		YES	NO
10.	Have you been pregnant in the last year?	NA	YES	NO
11.	Do you want to become pregnant in the next year?	NA	YES	NO
12.	Do you have a current list of medications? We will need list at your first appointment.		YES	NO

INSURANCE DISCLAIMER

Many insurance companies have specific requirements that must be met before surgery is approved.

Instructions:

1. Call the customer service number on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits for weight loss surgery for morbid obesity.
3. The Ohio State University Wexner Medical Center address where the surgery will take place is 410 W. 10th Ave., Columbus, OH 43210

Disclaimer:

- The Ohio State University Wexner Medical Center Bariatric Surgery Program is **NOT** responsible for incorrect information provided by the insurance company.
- Completion of this form does not mean that you are approved for weight loss surgery and does not guarantee payment for services. You will be responsible for any charges that your insurance does not cover.

The Ohio State University Wexner Medical Center
Comprehensive Weight Management Expectation Agreement for Bariatric Surgery

You are being considered for a bariatric procedure (Gastric Bypass Roux-En-Y, Sleeve Gastrectomy). You need to be aware of what you will need to do both before and after the surgery to be sure this is the right treatment for you. Since this is so important, this handout will describe our expectations and your commitment as a surgery candidate. The success of your procedure depends on your following a lifelong plan that includes:

- Regular clinic visits, procedures and lab tests
- Taking medicines every day for the rest of your life
- Regular physical activity
- Eating as directed to keep you healthy and at your targeted weight

I, _____, commit to myself, my family and the bariatric surgery team that I will take care of myself in the following ways:

Before surgery I will:

- Attend all of my clinic, test and lab appointments, and follow my clinical team recommendations while waiting for surgery. I will call to reschedule any appointments that I am not able to attend at least 24 hours in advance (this clinic has a strict no show/cancellation policy that may result in dismissal).
- Treat all staff respectfully. I understand that aggressive behaviors, swearing at or threatening staff and making racist, sexist, ethnic or homophobic comments could result in immediate dismissal from the practice.
- Take medications and vitamin regimen and follow any recommendation for behavioral therapy as determined by the clinical team.
- Have a primary care provider to help manage my health needs while waiting for and after bariatric surgery.
- Have a working telephone so I can be contacted for appointments at home or when away from home. I know I need to respond to calls from the bariatric team in a timely manner. I am aware that I will have to be able to participate in virtual appointments when necessary. MyChart is consistently used in this clinic and is strongly encouraged for our patients.
- Do my best to follow the eating plan given to me by the clinical team. When I am placed on a weight loss plan, I must continue to move toward my weight goal with diet and exercise.
- Not use any substances and drugs not prescribed by my doctors, or become pregnant. This includes:
    - Non-prescription drugs and misuse of prescription medication. I understand I must not have any dependence to any recreational drugs.
    - Tobacco use including cigars, cigarettes, chewing tobacco, snuff, vapes, e-cigarettes or pipes. I understand smoking promotes ulcers and general complications related to bariatric surgery.
    - Alcohol such as beer, wine or cocktails. I understand I cannot have any alcohol dependence for one year prior to surgery and following surgery to avoid transfer addiction. I understand non-adherence to this may result in weight regain or other complications.
    - Pregnancy: I understand that I have been advised to avoid pregnancy for 18 months following surgery and may not have had a pregnancy within 12 months prior to surgery.
    - I understand that I must avoid using NSAID medications after surgery and understand that taking NSAIDS after surgery may produce severe complications.
- Have random urine and blood tests for drugs, nicotine or alcohol. I know I must abstain from tobacco use for for life. I understand that i if a positive result is found, I will not be considered for candidacy.
- Call my insurance company to find out about my coverage for my procedure. I **understand that** I **am responsible for bariatric surgery costs not covered by my insurance. These may include hospitalization, provider charges, outpatient and laboratory charges and medicines.** We will have navigators help you through your process however, it is ultimately your (the patient) responsibility to be aware of your coverage.
- Follow all guidelines and recommendations set forth by my clinical care team in a timely manner and treat all members of the team with respect.
- Understand surgery dates and time frames cannot be guaranteed.
- Understand the average time to surgery is 8-12 months and will complete these recommendations in this time frame to continue to be a candidate for surgery.
- Understand that my care team is assigned prior to my initial visit and will be maintained throughout my entire time frame.

MS0014

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

EXPECTATION AGREEMENT FOR BARIATRIC SURGERY

MC202510 (7/17)

Patient Name:

Medical Record Number:

Date of Birth:

After Bariatric Surgery

I also know **after bariatric surgery and for the rest of my life,** I will be expected to:

- Take my medications and annual lab work as ordered by my care team.
- Meet protein and fluid intake requirements post-surgery to avoid dehydration, nausea and vomiting.
- Limit lifting, pulling or pushing of objects weighing more than 10 pounds for two weeks and 25 pounds for six weeks after my surgery or until my doctor tells me it is OK.
- Plan appropriately knowing that up to six weeks of FMLA will be supported by our team. It will start the day of my surgery and will be sent directly to my human resources department.
- Continue my care with my primary care provider, behavioral health and bariatric clinical team.
- Work with my primary care provider and/or chronic pain management provider if I need long-term pain medicine or short-term pain medicine other than during the time right after surgery.

My agreement

I know that I want to have bariatric surgery and I am willing to do what is needed. I understand that this is an elective procedure (a choice). If I feel like I am not able to do what is required, I will make an appointment with one of the clinical care team to talk about this. I also know that if I do not do what is needed or recommended by the care team, I will not be considered a candidate for bariatric surgery.

I sign that I have read and understand this form and agree to do what is needed for any bariatric procedure.

We understand this is a lifelong commitment and we take that very seriously for your well-being. Please understand that not everyone is a candidate for surgery and those decisions are made with regard to your safety and reviewed by our care team. This agreement in no way guarantees that you will be eligible for bariatric surgery.

Patient: _____

(print)

Signature :_____ Date/Time: _____

Copies of this contract will go to you, and be added to your medical record. Please keep this as a reminder of what you need to do.

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EXPECTATION AGREEMENT FOR BARIATRIC SURGERY

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Patient Name:

Medical Record Number:

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