

Advanced

Bariatric

Center

Dear Patient,

Welcome to the Advanced Bariatric Center of Fresno and thank you for choosing our Center to help you get a new start on life. I would like to tell you a little bit about how our Center works and what to expect over the next few weeks if you elect to undergo gastric bypass for morbid obesity. If this is your first visit to our office, you will fill out many forms to help us learn about you and to facilitate the insurance process. Unfortunately, the insurance companies have made this process very complicated and it is important that we follow their rules very closely if we are to successfully get you approved. After filling out the paperwork, you will be weighed and measured and your BMI will be calculated. It is important that we determine your Body Mass Index because there are strict criteria which determine whether you are eligible for the surgical treatment of morbid obesity.

Once the initial paperwork and vital statistics are taken, you will be seen by one of us in the office, either myself or Dr. Swartz. At this point we are trying to gather information to determine whether you are a candidate for the surgery, whether there are any contraindications to you having surgery, and whether you would like to be part of our Bariatric Center. No matter which one of us initially sees you, the process will be the same. In order that we may decrease delays in reaching your desired goal - the Operating Room- I am not able to perform all the initial Histories and Physicals. We will, however, review individually all of the paperwork with our staff to determine whether you are a good candidate for this surgery before we proceed in submitting your information to your appropriate third-party carrier. If you have any special needs, or we determine that further interviews or physical exams should be performed, you may be asked to come back to the office for further testing with myself or one of the staff before your information is submitted to your insurance company or you are scheduled for surgery.

Once all of your records have been reviewed by me and the appropriate staff, and all the necessary tests have been performed, then your information will be submitted to the appropriate insurance carrier. If you are paying for the operation yourself, and not going through an insurance company, then this portion of the procedure will obviously be expedited because it is unnecessary to wait for the insurance carrier's approval.

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Now comes the uncomfortable period during which you have to wait until your insurance company decides whether you are a candidate. There is not always a correlation between your severity of morbid obesity and your degree of illness and whether the carrier decides whether they will pay for the operation. This is very unfortunate, but it is a system under which you and I have to work. Hopefully, not too many days or weeks will go by before

we hear from your insurance carrier. When we do hear, we immediately contact you and at this point our surgery scheduler will determine what hospital is best for you and when you can be scheduled for surgery. When the date is scheduled, you will be given a preoperative appointment which you must attend. In addition, you must attend a seminar put on by my office either in the office or at Sierra Community Health Center Auditorium prior to your operative date. There are no exceptions to this rule. This seminar is a teaching experience and it is an opportunity for us to make sure that you understand all the principles of bariatric surgery, the expectations, and outcomes. It is also an opportunity for you to ask as many questions as you want and to hear others ask questions that you initially may not have considered. It is impossible for us to teach each one of you individually all the things we feel are necessary to understand the surgery and to continue with the proper lifestyle changes unless this is done in a group setting. It takes one to two hours at the seminar to go through everything. Obviously, it would be impossible to spend this amount of time with each patient individually in the office, and that is why we believe in the seminars.

What happens at your preoperative visit once your surgery has been scheduled? The answer is, you go through more teaching and meet individually with Dr. Swartz or myself to make sure that nothing has been left out. Again, we use the classroom setting to go over many things with you that we feel are important for your preoperative, as well as postoperative, well-being. It is important that you understand that we would like to do this on an individual basis, but this is impossible when one considers the amount of information we must give you. Each patient undergoes an estimated three hours of group education plus individual time with their surgeon and other staff. We know that many bariatric surgeons do not spend this amount of time in teaching their patients, but we feel this is what will give you the edge on succeeding in your new lifestyle. After you undergo your preop teaching, you will meet with your surgeons. Now is the time for you to ask any questions you may have, no matter whether they are simple, complicated, or whether you may think they are silly. There are no silly questions. During this time, your surgeon will go over with you any special problems that you have and make sure that you understand the importance of the step you are about to take into your future. Also during your preoperative visit, you will have your picture taken for our chart and will receive some items which will help get you started on your recovery. Please do not leave the office until you are satisfied that all of your questions have been answered. We are here to help you and want you to feel free to ask questions or question anything we have said. It has come to our attention that some people feel intimidated by the

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process, but rather we would like you to feel like you are joining our family. All of our patients are treated like they are part of our Center. I know this is a little different from the typical medical practice, but bariatric surgery is not your typical surgical procedure. It is a procedure which has the potential of changing your entire approach to the rest of your life.

Finally, you're on your way and will need to get some lab done just before surgery. Anesthesia requires that certain lab tests are done within the week before surgery and these will be requested, although you have many laboratory tests up to this point. It is also important that you have made your arrangements for your hotel stay if you are from out of town and that you know where the hospital is where you will be having surgery.

I know that this letter to you may seem a little long and rambling, but it is important that you understand that the Advanced Bariatric Center, its staff, and myself, are only here because of you. If you are unhappy, if you have any questions, or just want to talk, we are ready to listen. Thank you, again, for choosing the Advanced Bariatric Center of Fresno to begin your new adventure.

Sincerely,

Edward L. Felix, M.D., F.A.C.S.

WELCOME TO OUR OFFICE!

We would like to welcome you to our office and thank you for the trust you have shown us by becoming our patient. It is our goal to give you the finest medical treatment available and to assist you in any way possible to achieve your medical goals.

We feel the best patient/physician relationship can be achieved by open communication and understanding. This is only possible if you feel free to discuss any questions or problems you have with our policies. We encourage you to discuss with the appropriate person any questions that may arise.

This booklet has been prepared to help answer questions you may have about gastric bypass surgery and obesity. You should keep it handy and bring it with you to all of your appointments with our office.

The purpose of this book is for the education of bariatric patients of the Advanced Bariatric Center of Fresno. This is only one of the tools used for this purpose. The information within the book is accurate to the best of our knowledge. It is not meant to be used as a definitive source, but as a compilation of information on the subject of bariatric surgery. We deny any responsibility for decisions based solely on this book or for any inaccuracies, errors, or omissions therein.

WHAT IS OBESITY?

Severe obesity is a chronic condition that is difficult to treat. A body mass index (BMI) above 40, which usually means at least 100 pounds overweight for men and women, indicates that a person is severely obese. Your physician has probably called it morbid obesity. You can calculate your BMI with this formula: weight in pounds x 705 divided by your height in inches and then divide that number by your height in inches again. The result of this calculation is your BMI. A chart is included in this booklet for a quick way to find your BMI.

People with a BMI of between 35 and 40 and have other medical illnesses can also be classified as suffering from severe morbid obesity. People 20% or more above their desirable weight show an overall increase of 20% in the likelihood of death from all causes and a 25% increase in death from coronary artery disease (CAD). There is also a 10% increase of risk from stroke, a 40% increased risk of having gallbladder disease, and twice the risk of developing diabetes.

WHO IS A CANDIDATE FOR BARIATRIC SURGERY?

Not every morbidly obese person is a candidate for the Laparoscopic Gastric Bypass surgery. The following criteria must be met:

- ⇒ Patients are usually between 18 and 60 years of age.
- ⇒ No history of major psychiatric illness.
- ⇒ Weight of 100 pounds over normal for their height or a BMI \geq 40, or \geq 35 with comorbid factors such as hypertension, asthma, or diabetes. Many insurance companies will not cover the surgery if your BMI is under 40.
- ⇒ Patient must have documented support of their immediate family. Patient must have a personal physician who will support the patient for gastric bypass surgery and will actively follow them after their procedure if out of the local area.
- ⇒ No history of drug use or alcohol abuse.
- ⇒ If patient is under the care of a psychiatrist, this psychiatrist must document stability of patient for surgery and have a plan for management of depression postoperatively.
- ⇒ Patient must document commitment to participate in postoperative exercise and follow-up program.
- ⇒ Patient must have a complete understanding of the procedure, the risks and possible complications, and the lifelong changes in eating habits.
- ⇒ Patient must read and understand everything in this booklet and be willing and able to do the parts of the program that are their responsibility.

MEDICAL COMPLICATIONS OF OBESITY

Endocrine Abnormalities: Morbidly obese women have more irregularity in menstrual cycles, as well as more frequency of other menstrual abnormalities. There is also a higher frequency during pregnancy of having toxemia and hypertension. The onset of menarche is younger for obese girls.

Hypertension: In overweight young adults, ages 20-45, the occurrence of hypertension is six times that of normal-weight peers. Weight gain in young adult life is a potential risk factor for developing hypertension in later life.

Respiratory/Pulmonary Abnormalities: Pulmonary abnormalities are common in obese individuals. These include the less debilitating problems of decrease in lung volumes and expiratory reserve volume to the extreme of patients with sleep apnea, Pickwickian syndrome, somnolence, and hypoventilation. Obese patients often have disrupted sleep patterns from waking to "catch their breath."

Gallbladder Disease: Obese women in the 20-30 year age range have a six times greater expectancy of developing gallbladder disease than their normal-weight peers. Nearly one-third of obese women can be expected to have developed gallbladder disease by the age of 60. Fatty infiltration of the liver is also associated with obesity.

Degenerative Arthritis: A significant correlation between uric acid levels and weight has been found. The chance of gout is dramatically increased when a patient's weight is greater than 130% above the desirable. Weight loss will markedly decrease the obvious mechanical problem of stress on weight bearing joints that causes pain and loss of mobility. Obesity also increases the chance of developing osteoarthritis.

Cardiovascular Disease: It is calculated that for each 10% increase in body weight there is an approximate 20% increase in the incidence of coronary artery disease. Blood pressure increases 6.5 mm; cholesterol and glucose are both significantly increased.

Cancer: Morbidly obese men have a significantly higher mortality rate for colorectal and prostate cancer. A 20-year follow-up study showed that men who are 130% over normal weight are 2.5 times more likely to die of prostate cancer compared to their normal-weight peers. Menopausal women with upper body fat have an increased risk of developing breast cancer. Higher rates of uterine and ovarian cancer are found in morbidly obese women.

Psychological: There is no doubt that obese individuals have lifestyle restrictions. Mobility and physical incapacity due to back-joint problems and shortness of breath are very common among morbidly obese individuals. This can contribute to absenteeism and unemployment. Impairment of body image is a major form of psychological disturbance for the obese. Repeated failure of diet and exercise to help their "problem" causes a feeling of despair and depression.

TYPES OF SURGICAL PROCEDURES

Restriction Operations:

Creating a small pouch at the top of the stomach where food enters from the esophagus restricts food intake. Initially this holds about an ounce of food. This expands to hold 2-3 ounces with time. The outlet usually has a diameter of 1/4 inch. This delays the emptying of food from the pouch to cause a feeling of fullness.

With this procedure a patient eats only a half to one cup of food before experiencing discomfort or nausea. All food must be well chewed. The ability to eat large amounts of food is lost to most patients but some do return to eating modest amounts of food without feeling hungry.

Restriction operations for obesity include gastric banding and vertical banded gastroplasty. These both only serve to restrict food intake. This does not interfere with the normal digestive process.

Gastric Banding:

This procedure is performed by a band of special material being surgically placed around the stomach at the upper end. This creates a small pouch and a narrow passage into the remainder of the stomach.

Vertical Banded Gastroplasty (VBG):

This procedure is frequently used as a restrictive operation for weight control. In Figure 1 you can see that both a band and staples are used to create a small stomach pouch.

Weight loss is found in almost all patients with restrictive operations. In all weight loss operations success depends on patient motivation and behavior. Regaining weight is a risk. Approximately 30% of patients undergoing vertical banded gastroplasty achieve normal weight. *Risks* of this procedure include:

- ⊖ Vomiting caused by stretching of the pouch by food not chewed thoroughly enough.
- ⊖ Erosion of the band.
- ⊖ Breakdown of the staple line.
- ⊖ Leakage of stomach juices into the abdomen. The leakage would require an emergency operation.

Gastric Bypass Operations:

This type of procedure creates a small stomach pouch and bypasses part of the small intestine.

Extensive Gastric Bypass (biliopancreatic diversion):

With this more complicated gastric bypass operation (Figure 3) portions of the stomach are removed. The small pouch that remains is connected directly to the final segment of the small intestine. This completely bypasses the duodenum and jejunum. Although this procedure successfully promotes weight loss it is seldom used due to the high risk of nutritional deficiencies.

Gastric bypass operations cause malabsorption and restrict food intake that produce more weight loss than restriction operations that only decrease food intake. Generally, patients who have the bypass operations lose two-thirds of their excess weight within two years.

Risks for pouch stretching, band erosion, breakdown of staple lines, and leakage of stomach contents into the abdomen are about the same for gastric bypass as for vertical banded gastroplasty. Due to the gastric bypass causing food to skip the duodenum, where most iron and calcium are absorbed, risks for nutritional deficiencies are higher in these procedures. Anemia may result and decreased absorption of calcium may bring on osteoporosis and metabolic bone disease. Patients are required to take nutritional supplements that usually prevent these deficiencies.

Dumping syndrome may occur. This is where stomach contents move too rapidly through the small intestine. Symptoms include nausea, sweating, weakness, faintness, and diarrhea after eating, as well as the inability to eat sweets without becoming weak and sweaty and possibly having to lie down until symptoms pass. Generally, the more extensive the bypass operation, the greater the risk for complications and nutritional deficiencies. Patients with extensive bypasses of the normal digestive process require not only close monitoring, but also lifelong use of medications and supplements.

Jejunioleal Bypass:

This procedure is no longer performed in the United States. It was one of the earliest procedures for morbid obesity and achieved its results by shortening the overall length of the bowel to less than 10% of its normal length. This causes serious nutritional and metabolic side effects and contributed to

mortality in a significant number of patients. Patients who have already had this procedure need to be under close medical supervision and should consider a conversion to another weight control operation.

Roux-en-Y Gastric Bypass:

This operation is the benchmark to which other operations are compared for evaluation of their quality and effectiveness. A small pouch is created along the inner curve of the stomach and the small intestine is attached to the pouch. This procedure provides an excellent tool for long-term control of weight without the feeling of being deprived and hungry. Patients eat much smaller portions due to the pouch size, but they have the sense of fullness and satisfaction that makes them indifferent to even their favorite foods. They continue to enjoy eating, just much smaller portions. Nutrition is maintained by faithfully continuing to take vitamin and mineral supplements (Figure 2).

Laparoscopic Gastric Bypass Roux-en-Y:

This operation is similar to the conventional Roux-en-Y gastric bypass, but is performed with multiple mini-incisions. It has the advantage of avoiding a large incision which can break down and a faster recovery than a conventional bypass. Sometimes it is impossible to complete the bypass with mini-incisions and a mid-size incision, or conventional incision, will be done during the surgery to safely complete the operation. The surgeon makes this decision while the patient is under anesthesia; therefore, all patients must consent to both conventional and laparoscopic approaches before surgery.

Our center considers the Gastric Bypass Roux-en-Y to be the best of all the weight reduction procedures. By reducing the food intake and still utilizing the jejunum, patients have a satisfied full feeling with much less intake of food. Studies have shown this procedure to be excellent for long-term weight loss success but requires lifetime patient behavioral changes. This procedure may be done “open” or with “mini-incisions” and the use of laparoscopy. The decision of which procedure is best for you will be discussed with you at the time of your visit.

While everyone would be overjoyed if every patient reached their ideal body weight and stayed there, we expect on average our patients will remain somewhat overweight, but will no longer be morbidly obese. On average, patients lose two-thirds of their excess weight in two years, but typically they

gain back a bit after that time. After following patients for five years, the patient stabilizes with a loss of a little more than half of their excess weight.

Nationally, less than 25% of patients fail to lose significantly or regain to previous levels. Reasons for failure are usually a breakdown of staple line or gradual enlargement of the pouch. Both are usually a result of taking in too much food at once, overeating despite the surgery, excessive intake of high calorie liquids, or constant “nibbling.”

Our Center’s success rate is much higher than the national average. We believe that our careful screening process and mandatory program for follow-up are the cause of our success.

You are the most important factor. This is the best “tool” you will have for a healthier life.

NIH NEWS RELEASE

NATIONAL INSTITUTES OF HEALTH

National Heart, Lung, and Blood Institute

FOR RELEASE

CONTACT: NHLBI Communications
Office

10:00 a.m. Eastern time

(301)496-4236

Wednesday, June 17, 1998

First Federal Obesity Clinical Guidelines Released

The first Federal Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults were released today by the National Heart, Lung, and Blood Institute (NHLBI), in cooperation with the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK).

These clinical practice guidelines are designed to help physicians in their care of overweight and obesity, a growing public health problem that affects 97 million American adults - 55 percent of the population. These individuals are at increased risk of hypertension, lipid disorders, type 2 diabetes, coronary artery disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and certain cancers. The total costs attributable to obesity-related disease approaches \$100 billion annually.

“Overweight and obesity pose a major public health challenge. The development of these guidelines was a pioneering achievement since they were the first ever developed by the Institute using an evidence-based model and methodology,” said NHLBI Director Dr. Claude Lenfant. “This report will be an invaluable clinical tool for any health care professional who works with overweight or obese patients,” he added.

The guidelines are based on the most extensive review of the scientific evidence on overweight and obesity conducted to date. The review involved a systematic analysis of the published scientific literature to address 35 key clinical questions on how different treatment strategies affect weight loss and how weight control affects the major risk factors for heart disease and stroke as well as other chronic diseases and conditions. The guidelines present a new approach for the assessment of overweight and obesity and establish principles of safe and effective weight loss. According to the guidelines, assessment of overweight involves evaluation of three key measures—body mass index (BMI), waist circumference, and a patient’s risk factors for diseases and conditions associated with obesity.

The guidelines’ definition of overweight is based on research which relates body mass index to risk of death and illness. The 24-member expert panel that developed the guidelines identified overweight as a BMI of 25 to 29.9 and obesity as a BMI of 30 and above, which is consistent with the definitions used in many other countries, and supports the *Dietary Guidelines for Americans* issued in 1995.

BMI describes body weight relative to height and is strongly correlated with total body fat content in adults. According to the guidelines, a BMI of 30 is about 30 pounds overweight and is equivalent to 221 pounds in a 6' person and to 186 pounds in someone who is 5'6". The BMI numbers apply to both men and women. Some very muscular people may have a high BMI without health risks. The panel recommends that BMI be determined in all adults. People of normal weight should have their BMI reassessed in 2 years. "The evidence is solid that the risk for various cardiovascular and other diseases rises significantly when someone's BMI is over 25 and that risk of death increases as the body mass index reaches and surpasses 30," said Dr. F. Xavier Pi-Sunyer, chairman of the expert panel and director of the Obesity Research Center, St. Luke's/Roosevelt Hospital Center in New York City.

"The guidelines tell the truth about the risks associated with unhealthy weight. We hope that physicians and the public will take the message seriously and use the guidelines to begin to deal effectively with a difficult problem," asserted Dr. Pi-Sunyer.

According to a new analysis of the National Health and Nutrition Examination Survey (NHANES III), as BMI levels rise, average blood pressure and total cholesterol levels increase and average HDL or good cholesterol levels decrease. Men in the highest obesity category have more than twice the risk of hypertension, high blood cholesterol, or both compared to men of normal weight. Women in the highest obesity category have four times the risk of either or both of these risk factors. The guidelines recommend weight loss to lower high blood pressure, to lower high total cholesterol and to raise low levels of HDL or good cholesterol, and to lower elevated blood glucose in overweight persons with two or more risk factors and in obese persons. Overweight patients without risk factors should prevent further weight gain, advise the guidelines.

In addition to measuring BMI, health care professionals should evaluate a patient's risk factors, such as elevations in blood pressure or blood cholesterol or family history of obesity-related disease. At a given level of overweight or obesity, patients with additional risk factors are considered to be at higher risk for health problems, requiring more intensive therapy and modification of any risk factors.

Physicians are also advised to determine waist circumference, which is strongly associated with abdominal fat. Excess abdominal fat is an independent predictor of disease risk. A waist circumference of over 40 inches in men and over 35 inches in women signifies increased risk in those who have a BMI of 25 and 34.9. According to the guidelines, the most successful strategies for weight loss include calorie reduction, increased physical activity, and behavior therapy designed to improve eating and physical activity habits. Other recommendations include:

- Patients should engage in moderate physical activity, progressing to 30 minutes or more on most or preferably all days of the week.
 - Reducing dietary fat alone—without reducing calories—will not produce weight loss. Cutting back on dietary fat can help reduce calories and is heart-healthy.
 - The initial goal of treatment should be to reduce body weight by about 10 percent from baseline, an amount that reduces obesity-related risk factors. With success, and if warranted, further weight loss can be attempted.
 - A reasonable time line for a 10 percent reduction in body weight is six months of treatment, with a weight loss of 1 to 2 pounds per week.
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- Weight-maintenance should be a priority after the first 6 months of weight-loss therapy.

- Physicians should have their patients try lifestyle therapy for at least 6 months before embarking on physician-prescribed drug therapy. Weight loss drugs approved by the FDA for long-term use may be tried as part of a comprehensive weight loss program that includes dietary therapy and physical activity in carefully selected patients (BMI \geq 30 without additional risk factors, BMI \geq 27 with two or more risk factors) who have been unable to lose weight or maintain weight loss with conventional non-drug safety and effectiveness beyond one year of total treatment have not been established.
- Weight loss surgery is an option for carefully selected patients with clinically severe obesity—BMI of \geq 40 or BMI \geq 35 with coexisting conditions when less invasive methods have failed and the patient is at high risk for obesity-associated illness. Lifelong medical surveillance after surgery is a necessity.
- Overweight and obese patients who do not wish to lose weight, or are otherwise not candidates for weight loss treatment, should be counseled on strategies to avoid further weight gain.
- Age alone should not preclude weight loss treatment in older adults. A careful evaluation of potential risks and benefits in the individual patient should guide management.

According to NHANES III, the trend in the prevalence of overweight and obesity is upward. The guidelines note that from 1960 to 1994, the prevalence of obesity in adults (BMI \geq 30) increased from nearly 13 percent to 22.5 percent of the U.S. population, with most of the increase occurring in the 1990s.

“There are several possible reasons for the increase,” asserted Karen Donato, coordinator of the Obesity Education Initiative. “When people read labels, they’re more likely to notice what’s low fat and healthy, but may not be looking at calories. Also, more people are eating out and portion sizes have increased. Another issue is decreased physical activity. So people are consuming more calories and are less active. It doesn’t take much to tip the energy balance,” she said.

The upward trend in adult obesity has also been observed in children, notes the report. Since treatment issues surrounding overweight children and adolescents are quite different from the treatment of adults, the panel called for a separate guideline for youth as soon as possible. However, a healthy eating plan and increased physical activity is an important goal for all family members. With that in mind, the guidelines contain practical information on healthy eating. Based on this material, the NHLBI has developed consumer tips on shopping, eating, and dining out.

The guidelines have been reviewed by 115 health experts at major medical and professional societies. They have been endorsed by the coordinating committees of the National Cholesterol Education Program and the National High Blood Pressure Education Program, the North American Association for the Study of Obesity, and NIDDK Task Force on the Prevention and Treatment of Obesity, and the American Heart Association. These groups represent 54 professional societies, government agencies, and consumer organizations. *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* will be distributed to primary care physicians in the U.S. as well as to other interested health care practitioners. It is available on the NHLBI Website. Single free copies of the consumer tips referred to above are available by writing to the NHLBI Information Center, P.O. Box 30105, Bethesda, M.D. 20824-0105.

COMMITMENT TO LONG-TERM FOLLOW-UP

Gastric bypass has been shown to be very effective at inducing and maintaining major weight loss in severe obesity. After the initial high risk period, the long-term risks of gastric bypass are quite low. One major concern is the development of severe and sometimes devastating micronutrient and vitamin deficiencies. Most studies suggest that these illnesses can be prevented by meticulous attention to aggressive vitamin, mineral, and protein supplementation. This commitment is lifelong.

Because many studies suggest that a high proportion of successful patients will tend to assume that they have returned to normal and stop taking their vitamins, it is very important that patients be willing to commit to long-term follow-up. Physicians encourage patients to take their supplements and to perform yearly monitoring of their blood levels to warn of impending deficiency states.

LONG-TERM FOLLOW-UP:

- ☺ Patient will write a letter saying that they will stay in touch with Dr. Felix's office and their local physician on a regular basis.
- ☺ Patient will notify Dr. Felix's office and their regular physician of any changes in their address or telephone number.
- ☺ Patient will agree to meticulously take the appropriate multivitamin and protein supplements.
- ☺ Patients will arrange for yearly blood tests to allow monitoring of their vitamin and mineral levels and communicate results to our office.

LIFESTYLE COUNSELING:

Patients are to make an appointment with our Certified Fitness Practitioner through The Advanced Bariatric Center after having surgery. The Bariatric Preoperative Program will include nutritional counseling along with a one-half hour private fitness training session with body composition weights and measurements. We want to help you reach your best potential after your surgery. It has been our experience that patients who take full advantage of the program have the best long-term results. Because of this, the program is not voluntary, but is mandatory. A registered dietitian is available to help with nutritional questions. You may phone our office with questions for Dr. Felix, Dr. Swartz, or our staff.

ADVANCED BARIATRIC CENTER PROGRAM

We want to help you reach your best potential after your surgery. The many elements that make up the Advanced Bariatric Center Program provide the tools and the education to help you succeed with your bariatric surgery. It has been our experience that patients who take full advantage of the Advanced Bariatric Center Program have the best long-term results. Because of this, the program is not voluntary, but is mandatory.

Before your surgery you will have a preoperative appointment. This will be the longest appointment in our office. On that day you will meet with our fitness practitioner and with Dr. Felix or Dr. Swartz. The fitness practitioner will give you a baseline reading of your weight and fat percentages before surgery to allow you to accurately monitor your progress after surgery. At your preoperative visit you will be given a packet of certificates. These are redeemable for such things as an update evaluation of weight and body fat percentages. Another certificate is for your personal session with the fitness practitioner to learn exercises suitable to your particular needs. Other certificates may be included, as well as vitamins and supplement samples.

After surgery you will meet with a registered dietitian who will give you help with nutrition questions. Making good food choices is very important after surgery. Remember, surgery is not a quick-fix. It is a tool for you to use to improve your life. You have lifetime access to our support group meetings. If you cannot attend, log onto our online support group on the internet. Please, medical questions should always be addressed to the office and not asked on the internet.

You, as our patient, have full use of our expertise and resources. We have tried to provide all the elements necessary to help you succeed. Out-of-town patients may, at times, call us for a "telephone visit" rather than travel to our office. Or, they may arrange to include their follow-up visit on the same day as their session with the fitness practitioner. Many out-of-area patients simply include a visit with us in their annual vacation plans.

As time goes on and you are experiencing more changes, you may want to sit in on another nutritional session or phone with exercise or lifestyle questions. In some cases, a physician referral may be helpful to another expert such as a psychologist or other healthcare professional. We will gladly assist you in any way we can.

HOW TO PREPARE FOR YOUR SURGERY

— **If you live out of town:** If you live a great distance from Fresno, we will be happy to work with you in scheduling your consultation visit the same day as a seminar whenever possible. Patients who live more than an hour from Fresno must stay in town for 5-7 days after their surgery. Long trips put you at high risk for developing potentially dangerous, or even fatal, blood clots. We can provide you with a list of local motels.

— **Transportation home from the hospital:** You will need someone to drive you home from the hospital, whether you live out of town or locally.

— **Informed consent:** You must understand the goals, risks, and limitations of surgery-assisted weight loss. One or more meetings with your surgeon or his staff may be necessary to accomplish this goal. We require you to attend our seminar prior to having surgery, but not prior to your initial consultation. You must **carefully read all the literature given to you** and make sure that all of your questions are answered.

— **Initial consultation, evaluation of health status, including any additional evaluations:** Often, the patient must be referred to other specialists to be evaluated for other diseases. Please bring names and addresses of your doctors and specialists. If you have recently had a chest x-ray or EKG, arrange to have the reports forwarded to our office. This may reduce the waiting time for your surgery. We do **not** need your complete charts from other doctors. A lab slip will be given to you. This will include orders for blood tests, chest x-ray, and EKG. We have found that waiting to do this immediately before surgery sometimes requires canceling or postponing surgery due to abnormal laboratory tests. Getting these labs done before or immediately after your first consultation visit allows us to give you the best possible care.

— **Insurance company approval:** If you have insurance we must have their approval for surgery to take place and their approval may take weeks to receive. Our staff will do all they can to obtain this authorization, but the insurance situation may be beyond our control. **Approval does not guarantee payment from your insurance company.** We encourage you to call your particular insurance company and ask what amount, if any, will be your responsibility. There are far too many insurance plans for us to realistically be able to keep track of this detail. Again, we encourage you to check into this on your own.

- **When you have your surgery date**, call your primary care physician and arrange to have them help you closely monitor your medications for at least the first month after your surgery. Many medications, particularly for blood pressure and diabetes, need to be adjusted at frequent intervals during the first months postop.

- Before surgery we advise you to check with your pharmacist and doctors who prescribe your medications regarding the form the medication comes in. Some medications are too large for you to tolerate for a time after gastric bypass surgery. Liquids, chewables, patches, and small tablets are recommended until you are able to handle larger forms of medications. Some medications come in various forms or have equivalent substitutes that will be better tolerated. Also, if you take medications that contain aspirin or ibuprofen, or otherwise might cause stomach ulceration or bleeding, ask your doctor or pharmacist about alternative medications. We do not want you to take aspirin, ibuprofen, Motrin, or pill form potassium.

- **One to two weeks before your scheduled surgery date:** At this time you will have a preoperative office visit. This is for your final checkup to make sure it is safe to go ahead with your surgery. It is very important that you ask any remaining questions you may have before surgery. You will be given a laboratory slip for a current blood test. This should be done 5-7 days prior to surgery. At least one week prior to your surgery you should stop taking NSAIDS (includes aspirin, ibuprofen products, Naprosyn, and more). These thin the blood and can lead to excessive bleeding in surgery. We also recommend stopping herbal supplements at this time. You may resume taking them after the surgery. Taking your regular vitamins is encouraged.

- **Two days before surgery:** At this time you will be on a liquid diet avoiding alcoholic beverages and all milk products (fruit juice, Jell-O, soup broth, and popsicles are okay). You will also be required to purchase one bottle of magnesium citrate or a Fleets enema. These do not require a prescription. You will drink the magnesium citrate the day before your surgery. The night before your surgery you are to have nothing by mouth after midnight, including no water. If you are diabetic or if you take medications on a regular basis, ask Dr. Felix or Dr. Swartz and you will be given specific instructions.

IN THE HOSPITAL

- ✿ Wear loose, comfortable clothing to the hospital.
- ✿ **Bring medications** you use on a daily basis, including inhalers and CPAP.
- ✿ You should arrive at the hospital at the time we will give you in our office.
- ✿ The nurses will check to make sure all the required laboratory tests are documented.
- ✿ Your anesthesiologist will speak to you before your procedure. If you have had any previous surgery and had problems with anesthesia, please discuss this thoroughly with the anesthesiologist.
- ✿ If you have developed any new medical problems since your preoperative office visit including, but not limited to, cold, flu, broken bones, etc., tell the nurse you need to speak to your surgeon before the procedure begins.
- ✿ After your surgery, pain medication will be given intravenously by means of a PCA, or Patient Controlled Analgesia, machine. By using this you can give yourself doses of pain medication when you need it and the machine will keep you from getting too much.
- ✿ You may receive oxygen for the first 24 hours. The nurses will show you how to cough and do your deep breathing exercises. These exercises are very important and should not be neglected.
- ✿ **Avoid sitting with your legs down whenever possible.** It is better to rest with your legs elevated whenever you are not walking. Lying down is okay. Do not ride in a car or sit (such as in a movie theater or sitting at a computer) for longer than 40 minutes without getting up and walking briskly for 10 minutes during the first two weeks after surgery. This helps prevent risk of blood clots. You are at high risk for developing dangerous blood clots for 4-6 weeks after surgery. Avoid long trips during this high risk period!
- ✿ On your first postoperative day, your bandages will be removed. Usually no more need be applied.
- ✿ While in the hospital, you are on a full liquid diet with no sodas and no dairy products. If your tray is wrong (and this does happen), do not hesitate to let the nurse know and she will order you a new meal.
- ✿ Be sure to ask hospital staff if you are unsure about anything. They are there to help you recover as quickly as possible.

FOLLOW-UP

After you are discharged from the hospital you will need to be seen in our office in one week. The appointment card for this visit is given to you at your preoperative visit. If you have no complications you will then be scheduled for a one-month and then three-month checkup. After that, we will see you in six months and then on a yearly basis indefinitely. We may have you get labs done before some of your appointments.

If you move out of the area we will forward your records to your new physician. It is very important that you are monitored by a physician. If you cannot commit to follow up you should not agree to have the surgery.

Gastric bypass surgery comes with no guarantee of success. It is up to you, the patient, to fully cooperate with your surgeon and primary care physician in changing your eating habits and getting regular exercise.

You will be given a full set of discharge instructions as to what and when to eat, especially for the first two weeks. Your cooperation is essential to your success. Each patient is an individual and you may be on a liquid diet for up to a month, depending on your individual recovery.

**If at any time you have a medical emergency call:
(559) 431-8446.
A physician is on call at all times.**

DISCHARGE INSTRUCTIONS

REMINDER: *You must have someone to drive you home or to your motel.*

Cautions:

If a problem arises you are not sure of, call our office and we will do our best to help. The following are problems you should be aware of:

- × You should NOT have high fevers over 101.5°, night sweats, or shaking chills. If your temperature is still over 101.5° after two hours, please call the office.
- × You should be able to breathe comfortably without pain or shortness of breath. You should NOT be coughing up sputum or blood. Remember to breathe deeply and to cough and clear your lungs to help them to recover from your operation. Use your incentive spirometer (breathing toy) that was given to you at the hospital for at least two weeks following your surgery.
- × Watch carefully for the signs and symptoms of infection: Rapid pulse rate of over 100 beats per minute that does not slow down; fever greater than 101.5°; chills; increased redness or pus draining from the incision sites; increasing abdominal pain; nausea; vomiting; shortness of breath; excessive bleeding at the incision site. Please call our office immediately if any of these symptoms occur.
- × For the first week after discharge, to avoid dehydration you should sip a “liquid diet” each waking hour to take in enough fluid each day. Two quarts per day is recommended. If you get behind, do not try to take in large amounts to “catch up.”
- × “Liquid diet” after surgery includes fruit juice, broth, and protein drinks. Coffee and tea are okay, but since caffeine is a mild diuretic, compensate for liquid loss by drinking extra non-caffeine fluids. After your first postop appointment you may be started on a “mush” diet which includes foods such as cottage cheese, yogurt, soft eggs (soft boiled, poached, scrambled), Cream of Wheat, oatmeal, mashed potatoes (no added milk, etc.) and pureed foods without any lumps. Eat high-protein foods, not carbohydrate foods. Foods at this stage should be thinned enough so they will “pour” off of a spoon. Baby First foods are okay. Avoid milk and dairy products for at least the first two weeks, as these cause cramping and diarrhea in some patients. However, most patients do well with cottage cheese and yogurt at this stage. Again, strive for a high-protein low-carbohydrate diet.

Family members may think you are not getting enough to eat and may tempt or urge you to eat more. Resist this! If you are 100 pounds overweight you have enough extra calories in storage to support you for 6 months or more.

- × Depression: You and your family need to be aware of the risk of depression in

the recovery period. If these symptoms occur we need to be aware of them to discuss possible treatments. Watch for these signs of depression: Difficulty concentrating, remembering, or making decisions. Persistent feelings of sadness, anxiety, irritability, or excessive crying. Sleeping too little or too much. Excessive fatigue and decreased energy. Thoughts of suicide or death, feelings of helplessness, worthlessness, hopelessness, or guilt. Decreased interest in activities or pleasure, including sex. **Call our office if you experience these symptoms.**

- ✗ Do NOT smoke. Smoking even a little causes narrowing of your blood vessels which decreases circulation. This slows the healing process.
- ✗ You should not have burning, bleeding, or hesitancy when you pass urine. If this occurs, call our office.

Discharge Medications:

You will most likely be given three prescriptions. Follow the instructions carefully and do not allow others to use your medications.

The first prescription will be for pain and will be in liquid form. It will most likely be Lortab, a liquid Vicodin. It is best to use liquid Tylenol instead for mild pain, as the Lortab causes constipation. There is also a medicine that reduces the risk of developing gallstones. This is not prescribed for patients who have had their gallbladders removed. An antacid will also be prescribed to help your new stomach adjust to your new life.

Multivitamins need to be taken three times daily. Do not take them all at once, but spread them throughout the day. You should be taking chewables plus iron. Also, chew two Tums per day—again, not both at once. After the first month, you may switch to a soft gel-cap type of vitamin. You should take the recommended dose once per day and add one extra every other day. If you have any question regarding brands, our staff will be happy to help. Regrettably, vitamins are not covered by insurance.

What to Expect:

- ✓ You should be alert and oriented, almost back to normal, the day of discharge. Tiredness is normal.
- ✓ You should be able to walk often during the day and move about without dizziness or lightheadedness or excessive pain. Your amount of activity will be regulated by how good you feel. You may do light housework as tolerated with no heavy lifting or strenuous activity until you come in for your first postoperative visit.

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- ✓ You will tire more quickly for a few weeks after surgery, but your energy level

will increase as you recover.

- ✓ Remember that you have a new and very small stomach. Eat and drink very slowly and only small amounts at a time. **Don't rush it.** Take time to chew your food very thoroughly. If you have pain or vomiting or a sensation that food is "stuck", stop eating and remain in an upright position for 1 to 2 hours. If symptoms subside, start with liquids again and take Mylanta or a similar antacid, 1 tablespoonful every 2 hours. If vomiting persists, call our office. A doctor is on call 24 hours a day.
- ✓ If you experience faintness, confusion, sweating, rapid pulse and anxiety, with or without cramps, diarrhea, stomach rumbling or nausea, you may be suffering from "dumping syndrome." The solution is to eat more slowly, avoid high calorie liquids (i.e. soda, milk shakes, or added sugar to tea or coffee). Allow at least 15 minutes between taking liquids and solids.
- ✓ There may be some clear or slightly bloody discharge from your wounds. This is normal. Shower without bandages and pat the areas dry. You will not need to apply further bandages. The Steri-Strips that are directly on the skin will fall off on their own. This is not a problem. There should be no foul odor or green-colored discharge from your wounds. If there is, call our office.
- ✓ Bruising around the wounds is normal and should decrease daily after the first week.
- ✓ There will be no restrictions on physical activity such as driving, household chores, or sex, but you should expect to be off work for 1 to 3 weeks, depending on your occupation. Use good common sense. **Remember, no prolonged sitting for 2 to 4 weeks after surgery.**
- ✓ At Week Four you should be able to start a solid diet. Start slowly and eat only a few tablespoonfuls at a sitting. Avoid meat that has not been ground or finely cut, and also fibrous foods such as canned spinach and citrus fruit pulp. Watch out for pits and seeds. Remember to leave a minimum of 15 minutes between your solids and liquids to avoid "dumping syndrome." This prohibition may be relaxed over time. Remember to **chew, chew, chew.** Your new stomach and the opening to the intestine are very small and only well-chewed foods will pass through without causing problems. **CAUTION:** Be careful of what you put in your mouth. Chewing gum, large seeds, popcorn, and hard candy such as breath mints or Life Savers can become lodged and be dangerous. Even such foods as Goldfish Crackers not well-chewed have resulted in emergency situations.

- ✓ If you do not have a good tolerance to your solid diet, go back to liquids for a

day or two and then try again. Patience is required. You are eating much less and much slower than you ever have before.

- ✓ Avoid high carbohydrate foods such as chips and pretzels. Eating snacks can cause you to regain your weight. Avoid breads, rice, and pasta. They expand and can cause potentially dangerous blockage. **Always eat your protein first, followed by vegetables and fruits.** This way, you get the protein and good nutrition you need and avoid too many carbohydrates.

DIET FOLLOWING GASTRIC BYPASS SURGERY

It is important for you to understand that not only must your calorie intake be less, but the quantity of your food, the consistency, and the types of foods you choose in the future are essential to your success. Our goal is to assist you by educating you on how your new stomach works best.

It takes about a month for your new stomach to heal 95%. During this time you need to be very aware that excessive eating is possible but dangerous to your health, as well as to your goal of weight loss. Before your stomach is properly healed, you could cause a leak by stretching the staple line to the limits or by stretching the pouch to a size so large that the benefit of the surgery is lost.

Your new stomach holds about an ounce. This space should be filled with nutritious **liquids only** for the first week. After that you may add soft pureed foods such as baby food, cottage cheese, yogurt, and soft-cooked eggs. Thinned mashed potatoes, Cream of Wheat, oatmeal, etc., can be part of this diet for variety, but the majority of your food should be proteins. Foods should “pour” off of a spoon. The third week try one (soft) solid food at a time, such as well-cooked vegetables, tuna, or moist chicken. Cut the food into small pieces and chew, chew, chew.

Early dumping syndrome is caused by too rapid entry of hyperosmotic foodstuffs into the intestine, by either washing down solid meals with high calorie liquids (non-diet soda, coffee or tea with sugar, milkshakes) or overfilling the pouch. Your bloodstream sends fluids to dilute the food causing a rapid decrease in the volume of circulating blood and a rapid increase of fluid in the intestine. The distention of the intestine may cause nausea, cramps,

diarrhea, and abdominal rumbling. The loss of volume from the blood may lead to low blood pressure with faintness and compensating release of adrenaline which causes pallor, sweating, a rapid pulse, and anxiety.

Late dumping syndrome is when the foodstuffs enter the intestine rapidly, and glucose that results from their digestion enters the bloodstream rapidly. This results in an unusually high amount of insulin to deal with the glucose load. After the glucose has all been absorbed, insulin production may suddenly be too high for the decreased amount of glucose that is entering the circulation. The result is hypoglycemia, causing pallor, sweating, rapid pulse, anxiety, and sometimes even confusion. The digestive symptoms of cramping and diarrhea are usually avoided with late dumping.

The absorption of vitamins and minerals may be changed because food is bypassing most of the stomach and duodenum. You will need lifelong supplements of vitamins and minerals. For this reason, regular monitoring of your vitamin and mineral levels is essential.

Milk sugar (lactose) is difficult to digest. Milk sugar passes into the colon which is not designed to deal with it and where it is subject to fermentation by cooling bacteria. Nausea, cramps, gas, and diarrhea may result. For this reason, milk and milk products should be added *cautiously* no sooner than two weeks after your surgery. If they do not cause symptoms they may be taken freely. (Cottage cheese and yogurt usually do not cause these problems.)

A normal stomach grinds food up into tiny particles less than 1/16 of an inch. However, this is done in the lower part of the stomach where your food no longer goes. If you do not thoroughly chew your food, it may block the outlet of the pouch and make you vomit, or it may even have to be removed by special techniques such as gastroscopy. You must also not put anything indigestible into your mouth, such as a coin or gum. If accidentally swallowed, this could be disastrous.

Protein is important to your health. Each day you need to have a minimum of 60 grams of protein in your diet. The healthy food you eat helps, but you need supplements. You may take extra protein in the form of liquid, powder, or we have bars and cookies available. You need to have a protein powder or liquid at home when you are discharged from the hospital. A sample will be included in your preoperative package. You may also purchase this from us or from another source before your surgery. The other forms of protein may be added when your diet has advanced to the appropriate stage. Many protein supplements are high in sugar and carbohydrates. Look for high protein, low sugars, low carbohydrates. **READ LABELS!**

We have tried to cover as many of your questions about your postoperative diet as possible. Please do not hesitate to ask Dr. Felix, Dr. Swartz, or our staff if you are unsure about anything regarding your surgery or recovery.

SERIOUS AND/OR LIFE THREATENING COMPLICATIONS

- ⇒ The risk of dying from Roux-en-Y Gastroplasty is slightly less than 1%.
- ⇒ About 10% of patients have some trouble with the lungs postoperatively and 2% develop pneumonia.
- ⇒ Perforation or leak from the surgical connections occurs in about 2% of cases.
- ⇒ The spleen (blood-filled organ next to the stomach) may be injured in 1-2% of cases, requiring removal of the spleen.
- ⇒ Gaseous distention of the lower part of the stomach postop is rare but may require re-operation for gastrostomy (drainage tube temporarily placed in stomach).
- ⇒ Pancreatitis.

PROBLEMS THAT ARE USUALLY LESS SERIOUS

- ⇒ Wound problems such as bleeding (2%) or infection (5%).
- ⇒ Incisional hernia may eventually develop in about 10% of cases. This is similar to the risk of any abdominal incision in seriously overweight patients.
- ⇒ The pouch opening (stoma) into the intestine may ulcerate (up to 15%) or narrow (stenosis) over time, causing excessive weight loss or persistent vomiting. An endoscopic procedure (EGD) can diagnose ulcers and treat stenosis. We prescribe a bedtime dose of a stomach acid blocker to help prevent ulcers. Re-operation is required in less than 2% of bariatric patients.

- ⇒ Stenosis is a narrowing at the outlet of the gastric pouch. It usually occurs between 4 and 8 weeks postop. Statistically, it occurs in less than 10% of gastric bypass patients. Symptoms include failure to advance the diet beyond soft, pureed foods; feeling like foods are getting “stuck”; vomiting (particularly a foam or white mucous). Notify the office if you think this might be happening. DO NOT wait until you can no longer keep down liquids or dehydration may result. Dehydration happens quickly and may become serious if ignored.
- ⇒ Vitamin or mineral deficiencies may occur. This is almost always prevented by taking multivitamins daily. Periodic checks are needed to detect deficiencies.
- ⇒ With rapid weight loss there is at least a 25% risk of gallstones. A medication to reduce this risk will be given to you. It should be taken daily for 6-12 months, as determined by the doctor. You may need your gallbladder removed at a later time.

NUISANCE OR TEMPORARY COMPLICATIONS

- ⇒ Dietary intolerance: These are almost universal but vary from patient to patient. Most patients cannot eat red meat, but most can eat chicken, fish, and ground meats.
- ⇒ Hair loss (20%) — both men and women.
- ⇒ Dry skin.
- ⇒ Menstrual irregularities.
- ⇒ Rib pain from retraction to expose the stomach during surgery.
- ⇒ Change in temperature perception.
- ⇒ Changes in interpersonal relationships (not always to the better) are also common.
- ⇒ Loose, unsightly skin. Insurance companies consider surgery for this to be cosmetic and will not, therefore, pay for this type of procedure.

RISKS/COMPLICATIONS OF GASTRIC BYPASS SURGERY

- **Depression** Depression is a common medical illness and has been found to be particularly common in the first weeks after an operation.
- **Allergic Reactions** From minor reactions such as rash to sudden overwhelming reactions that can cause death.
- **Transfusion** Including hepatitis and Acquired Immune Deficiency Syndrome (AIDS) from the administration of blood or blood components.
- **Anesthetic** Used to put you to sleep for the operation, anesthesia can be associated with a variety of complications up to, and including, death.
- **Bleeding** From minor to massive bleeding that can lead to the need for emergency surgery, transfusion, or death.
- **Blood Clots** Also called deep vein thrombosis (DVT) and pulmonary embolus, this can cause stroke or even death.
- **Infection** Including pneumonia, wound, bladder, skin, and deep abdominal infections that can all sometimes lead to death.
- **Leakage** After operation to bypass the stomach the new connections can leak stomach acid, bacteria, and digestive enzymes causing a severe abscess and infection. This can require repeated surgery and intensive care or even death.
- **Narrowing** Narrowing (stenosis) or ulceration of the connection between the stomach and the small bowel can occur after operation, requiring endoscopy and possible dilatation.
- **Dumping** Dumping syndrome symptoms include cardiovascular problems with weakness, sweating, nausea, diarrhea, and dizziness.
- **Bowel Obstruction** Any abdominal surgery can cause scar tissue that can put the patient at risk for bowel obstruction.
- **Hernia** Any incision in the abdominal wall can lead to hernias.

PATIENT LETTER

To improve patient education and understanding, we require our patients to write a letter showing that they understand the possible benefits and risks of gastric bypass surgery. This requirement is based upon educational research showing that retention of information is improved by asking the learner to think about and write down the information.

Patients who are not able to understand enough to write a letter detailing the benefits and risks of the operation will be considered poor candidates for gastric bypass surgery. Patients must write their own letters.

LETTER MUST CONTAIN UNDERSTANDING OF:

- ✍ Morbid/clinically severe obesity
- ✍ Risks of obesity
- ✍ Expected benefits of surgery
- ✍ Possible risks of surgery (please list risks)
- ✍ How the operation is performed
- ✍ Why the operation is performed
- ✍ Operation may be done laparoscopically but may need to be done open.
- ✍ Alternatives to surgery
- ✍ Postoperative diet changes
- ✍ Possible depression after surgery
- ✍ Need for long-term follow-up
- ✍ Need for vitamin and protein supplements lifelong

Please cover all of these points. If your letter does not demonstrate a clear understanding of all of these areas you will be asked to write another letter. It is very important that you fully understand the surgery and life changes that you are consenting to before you have this surgery done. Be brief and to the point. Your letter does not need to be long.

Your letter should have the date and your signature, along with the signature of your spouse, parent, or other adult who will be assisting you in your recovery. PLEASE HAVE THIS LETTER WITH YOU AT YOUR FIRST OFFICE VISIT.

RISK FACTORS

Many of the risks and complications of this surgery are detailed in the booklet you received from our office. These are found under the headings “Serious and/or Life Threatening Complications,” “Problems that are Usually Less Serious,” and “Nuisance or Temporary Complications.” They are summarized below.

- ✓ **Hair Loss** Many patients develop hair loss for a short period after the operation. This usually responds to increased levels of vitamins and protein but can be permanent.
- ✓ **Deficiencies** After gastric bypass there is a malabsorption of many vitamins and minerals. Patients must take vitamin and mineral supplements forever to protect themselves from deficiencies. Supplements include, but are not limited to, multivitamins, calcium, and protein.
- ✓ **Pregnancy** Vitamin and mineral deficiencies can put the newborn babies of gastric bypass mothers at risk. No pregnancy should occur for the first year after the operation and patients must be certain to inform their gynecologist of this surgery if they later become pregnant.
- ✓ **Laparoscopic Surgery Risks** Laparoscopic surgery uses punctures to enter the abdomen and can lead to injury, bleeding, or death. Other risks of this surgery include injury to the spleen, stapler malfunction, and the necessity to convert from a laparoscopic to an open procedure.
- ✓ **Death** The risk of dying from Roux-en-Y gastroplasty is slightly less than 1%. As with any surgery, there is this risk.
- ✓ **Other** Any major abdominal surgery, including gastric bypass, is associated with a large variety of risks and complications, both recognized and unrecognized, that may occur either soon after long after the operation. These include pneumonia, infection, blood clots, and leakage. Postoperative stenosis is not uncommon after this surgery and may require treatment. The occurrence of developing gallstones is increased with rapid weight loss.

Body Mass Index (BMI) Chart

BMI:	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Height	Body Weight (Pounds)																	
58"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172
59"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178
60"	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184
61"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190
62"	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196
63"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203
64"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209
65"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216
66"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223
67"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230
68"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236
69"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243
70"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250
71"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257
72"	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265
73"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272
74"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280
75"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287
76"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295

Find your height in the far left column. Move across to your weight. The number at the top of that column is your BMI.

Body Mass Index (BMI) Chart

BMI:	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height	Body Weight (Pounds)																	
58"	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59"	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60"	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61"	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62"	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63"	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64"	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65"	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66"	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67"	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68"	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69"	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70"	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71"	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72"	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73"	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74"	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75"	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76"	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Find your height in the far left column. Move across to your weight. The number at the top of that column is your BMI.

EDWARD L. FELIX, M.D., INC.

Patient's Name (First, Middle Initial, Last): _____ Date

of Birth: ____ / ____ / ____ Male ___ Female ___ SS#: ____ - ____ - ____

Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____

Cell Phone: (____) _____

Employer: _____ Phone: (____) _____

Married ___ Widowed ___ Single ___ Divorced ___ Spouse's Name: _____

Spouse's Employer: _____ Phone: (____) _____

EMERGENCY CONTACT: Relative or friend not living with you who we can contact in case of emergency:

Name: _____ Relationship: _____ Phone: (____) _____

PRIMARY CARE DOCTOR (your regular doctor): _____ Phone: _____

REFERRING PHYSICIAN (who sent you here): _____

HOW DID YOU HEAR ABOUT US:

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father's Name: _____ Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Employer: _____

Mother's Name: _____ Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Employer: _____

INSURANCE INFORMATION (Please fill in even though we make a copy of your card.):

Primary Insurance: _____ Policy #: _____ Group#: _____

Secondary Insurance: _____ Policy #: _____ Group#: _____

IF INSURED UNDER SOMEONE ELSE'S POLICY:

Policyholder's Name: _____ SS#: ____ - ____ - ____

Relationship to Policyholder: _____

Office staff has permission to leave messages regarding office visits on answering machines or with person answering the phone at home: YES ___ NO ___ At patient's workplace: YES ___ NO ___
On cell phone voice mail: YES ___ NO ___

I consent to treatment and guarantee payment in full for any charges incurred:

Date: _____ Signature: _____

Please give receptionist your insurance cards so we can make copies for our records.

PATIENT INFORMATION

Please fill in **all** the information on the following pages. Print clearly using a pen, not pencil.

Patients with a Body Mass Index (BMI) of 40 or more are candidates for bariatric surgery. Patients with a BMI of 35-39 are candidates for bariatric surgery if they also have comorbid medical problems such as sleep apnea, hypertension, asthma, etc. There is a chart in your book to help you determine your BMI.

Please be as complete as possible. We know this is a lot of paperwork, but it is necessary for us to help you. This form will be used to help us evaluate your health and medical history. It will also be used to provide the necessary information to get approval from your insurance company for your surgery. ***Have this form filled out before you come for your bariatric consultation. Bring this book with you. Thank you!***

Name: _____ Age: _____
 First Middle Last

Date of birth: _____ / _____ / _____ SS#: _____ - _____ - _____
 Month/ Day/ Year

If you live outside the Fresno-Clovis area, how many miles from our office do you live: _____ How long of a trip: _____

Date of filling out this form: _____

NOTICE - PLEASE READ BEFORE YOU SEE THE DOCTOR

Surgery sometimes requires the use of blood or blood products. If you will not agree to the use of such products, please inform us BEFORE we do your workup.

1. MEDICATIONS YOU TAKE (daily, occasionally, or "as needed"). Include both prescription and non-prescription drugs, and vitamins, supplements, herbal products, etc.

Name of Medication	Strength	Dose	Reason for taking
<i>Ex:</i>			

2. **SURGICAL HISTORY** Please list surgeries you have had.

TYPE OF SURGERY

YEAR

3. PSYCHIATRIC HISTORY

Have you been evaluated for psychological problems causing your obesity?

YES ___ NO ___ Results:

Have you ever seen a psychologist/psychiatrist/therapist in the past?

YES ___ NO ___ If so, for what reason and when?

Are you currently seeing a psychologist/psychiatrist/therapist?

YES ___ NO ___ Reason:

4. ALLERGIES TO MEDICATIONS

Name of Medication

Reaction it causes (Ex.: rash, swelling)

_____	_____
_____	_____
_____	_____

Problems with anesthesia? YES _____ NO

If YES, describe:

5. THYROID PROBLEMS

Have you been tested for thyroid problems? YES ___ NO

Have you ever had thyroid problems? YES ___ NO

Are you taking thyroid medication? YES ___ NO

If you are taking thyroid medication, has it affected your weight (i.e., gained or lost weight)? YES

___ NO

If so, describe: _____

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6. DIET and DIET MEDICATION HISTORY

The page titled "Weight Loss Attempts" must also be completed. You will find it later in this packet.

List **DIETS** you have tried (medications on next page) starting with the most recent. (Examples: Weight Watchers, Atkins, Slim Fast, Pritikin, Jenny Craig, diabetic diet, low carbohydrate, liquid, etc.) Give **DATES** in month/year and **amount of weight lost FOR THE PAST TWO YEARS**. For older diets just give the name or description of diets.

DIET	STARTED	STOPPED	WEIGHT LOST	WEIGHT GAINED BACK (Some/All/More)
Ex: Pritikin	02/99	08/99	22 lbs	More
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Have you tried others but cannot remember the names? YES _____ NO

Have you ever dieted under your doctor's supervision? YES _____ NO

DIET MEDICATION	STARTED	STOPPED	WEIGHT LOST	WEIGHT GAINED BACK (Some/All/More)
Ex: Phentermine	08/99	02/00	40 lbs	More
1.				
2.				
3.				

Have you ever taken Fen-Phen, Redux, or Pondimin? YES _____ NO

7. ATTEMPTED WEIGHT LOSS METHODS

Please check all of the following methods you have tried:

METHOD	YES	NO	METHOD	YES	NO
Diets	__	__	Exercise		
Counseling	__	__	Hypnosis		
Diet medicines (prescription)	__	__	Diet medicines (non-prescription)		
Ear staple/ acupuncture	__	__	Fasting/ starvation		
Support Group	__	__	Injections		

ATTEMPTED WEIGHT LOSS METHODS (continued)

Other methods of weight loss tried:

Worked on weight loss with a **doctor**:

YES ___ NO ___ Year(s) _____ Length of Time

Names of these doctors:

Worked on weight loss with and **nutritionist**:

YES ___ NO ___ Year(s) _____ Length of Time

Worked on weight loss with and **dietitian**:

YES ___ NO ___ Year(s) _____ Length of Time

Do you find it harder to lose weight as you get older? YES ___ NO

8. **TIMECOURSE**

Your Age Now: _____ How long have you been overweight:

Since age: _____. (OR) For _____ years.

Within a 20-pound weight gain or loss, how many months/years have you been at your current

weight? _____ What has been your heaviest weight? _____ lbs. Year:

What has been your largest amount of weight lost throughout your diet history? _____ What

year? _____ What weight loss program (diet, medicine, etc.) was that with?

_____.

9. WEIGHT LOSS ATTEMPTS — This is the Diet History we may send to your insurance company. You may be denied by your insurance company without this page completed.

At what age did you start dieting?

Please check all that apply.

- Diet prescribed by your doctor Low-Calorie Diet
- Jenny Craig Cambridge Diet Low-Carbohydrate
- Diet Center Pritikin Low-Fat Diet
- Atkins Scarsdale Diet High-Protein Diet
- Weight Watchers Lean Cuisine Healthy Choice Meals
- Nutri-Systems Prism Diet Hollywood Diet
- TOPS Fruit Diet Gloria Marshall
- Susan Powter Bahamian Diet Weight Loss Camp
- Diabetic Diet No-Sugar Diet Grapefruit Diet
- Liquid Diet Vegetarian Diet Cabbage Soup Diet
- Stillman Diet Diet Teas Schick Center
- Mayo Clinic Diet Rotation Diet The Zone
- Overeaters Anonymous Richard Simmons Deal-A-Meal
- Weigh Down Colorad Choose-To-Lose
- Beverly Hills Diet High-protein low-carbohydrate
- Inpatient Program for Weight Loss Body for Life
- Lindora Physicians Weight Loss Center Somersize
- Metabolife Metabo-Lite Slim Fast
- California Slim Acutrim Cal Ban 3000
- Herbalife Fastin Redux
- Phentermine Ephedrine Fen-Phen
- Pondimin Ionamin Tenuate
- Xenical Meridia Optifast
- Medifast RX Fast Nestles Sweet Success
- B-12 Injections B-6 Injections HCG Injections
- Body Solutions Fat Burners Dexatrim
- Chromaslim Bioslim Celexa
- Diuretics (water pills) Laxatives Amphetamines
- Purging (self-induced vomiting) Fasting
- Acupuncture/Ear Staple Body Wraps Jaw Wiring

- Hypnosis Group Counseling Individual Counseling
 Church Diet Group Other Diet Group Joined a Gym
 Aerobics Classes Purchased Exercise Equipment Tae Bo
 Hired Personal Trainer Exercise Videotapes
 Attended Exercise Classes Water Aerobics Class P.5

10. COMORBID FACTORS — Obesity Related Medical Problems

Please read carefully and make sure you write an "X" on each line.

I

MEDICAL PROBLEM	NOT		TAKE MEDICINE	
	YES	NO	FOR THIS	
		SURE	YES	NO
High Blood Pressure				
Heart Problems				
Stroke				
Fatty Liver (<i>hepatic steatosis</i>)				
High Cholesterol				
Asthma (not to be confused with allergies)				
Sleep Apnea(documented) Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Sleep Apnea (un-documented)				
Reflux (<i>GERD,</i> <i>frequent heartburn</i>)				
Urinary Incontinence (<i>can't hold urine</i>) Use pads for this?				
Degenerative Joint Disease (DJD)				
Arthritis				
Joint Pain (back, knees, ...)				
Heel Spurs				
Gout				
Varicose Veins Painful?				
Rashes Due to Skin Folds				
Diabetes				
Thyroid Problems				
FEMALES:				
Infertility (if not from tubal ligation, menopause, or hysterectomy)				
Irregular Periods				

Polycystic Ovarian Disease

Excessive Amount of Hair

Face _____ Body

Have you been diagnosed with hirsutism? YES _____ NO

PLEASE! If you checked "YES" for any medicines make sure that medicine is listed on Page 1 (include prescription, non-prescription, herbal).

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Use the following lines to give **details or descriptions** about medical conditions mentioned on the previous page, or other medical conditions, that you feel should be known to your doctor.

(ex.: Incontinence--Only when I cough, sneeze, or laugh.)

If you get frequent pain in any of the following areas, please write an "X" where it applies to you.

PAIN IS:	Mild	Moderate	Severe	I take medicine
	<i>(Not Bad)</i>	<i>(Pretty Bad)</i>	<i>(Very Bad)</i>	for this

NECK

BACK

HIPS

LEGS

KNEES

ANKLES

FEET

If you get **swelling** in any of the areas listed ABOVE, please **circle** the ones that apply.

MEDICAL PROBLEMS WE FORGOT TO MENTION

Are there any medical problems or symptoms not mentioned in this form you feel your doctor should know about? **YES** _____ **NO**

Describe/Explain:

LIST THE DOCTORS YOU SEE, their area of specialty, and the problems you see them for.

11. PROBLEMS IN DAILY LIVING BECAUSE OF OBESITY

A. List problems you have **AT YOUR JOB** due to your size, weight, or weight-related physical problems such as shortness of breath. (*Examples: Don't fit in regular office chairs. Cannot easily reach computer keyboard. Sitting for long periods causes back pain, feet swell.*) **Give as many specific examples as possible.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

B. List problems you have **in your PERSONAL/FAMILY life** due to obesity and related problems. (*Examples: Personal hygiene is hard because I cannot reach where I need to. I do not fit into public restrooms. Other examples of difficulties could be: Playing or caring for children, getting out of bathtub, can't bike ride with family, avoid social activities because of embarrassment about your size, doing yard work, housework, bathing, dressing, sex, taking walks, bending.*) **Give as many specific examples as possible.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

12. POSSIBLE CAUSES FOR YOUR OBESITY/FAMILY HISTORY

A. FAMILY HISTORY OF OBESITY (Write in number of brothers and sisters in their correct weight categories.)

	Normal Weight	Overweight (Up to 50#	Obese (Up to 100# over ideal)	Morbidly Obese (More than 100# over ideal)
Father	_____			
Mother	_____			
Brother(s)	_____			
Sister(s)	_____			

Medical Problems

Father

Mother

Sisters

Brothers

HEREDITARY Health Risks – List health problems that **other family members** have had(diabetes, heart problems, asthma, etc.)

RELATIONSHIP TO YOU (uncle, grandfather, etc.)	MEDICAL PROBLEM/DISEASE
<u>ex: Maternal grandfather</u>	<u>Obesity, thyroid cancer.</u>

Family members who are deceased (including parents, grandparents, brothers, sisters, aunts, uncles, and your children):

RELATIONSHIP TO YOU	AGE DIED	CAUSE OF DEATH
---------------------	----------	----------------

13. SOCIAL HISTORY

A. Marital Status:

Single ___ Married ___ Separated ___ Divorced ___ Widowed

Children: How many? ___ Ages

Stepchildren living with you: How many? ___ Ages

Do you take care of young children at home?

How many? _____ Ages:

B. Employment:

Do you have a job?

Self-employed: ___ Full-time: ___ Part-time

What type of work/business?

Your title or what you do:

Homemaker:

Currently on Disability: ___ Permanent ___ Temporary

Reason for disability:

C. Use of alcohol: Yes ___ No

Estimate how many drinks (**write in a number**):

Daily ___ Monthly ___ Yearly

D. Use of tobacco: Never ___ Current smoker ___ Age started ___ 1 pack/week ___ 1 pack/day

___ 2 packs/day ___ More

Ex-Smoker ___ Quit smoking in (year)

How long did you smoke?

D. Use of recreational drugs: Never

Currently ___ Type/frequency

Used in the past: YES ___ NO ___ If YES, how long ago?

Type/frequency

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14. MORE MEDICAL HISTORY

Some of this may be repeated elsewhere in this form. However, please be complete, as **this is required by insurance companies**. Thank you.

Do you have, or have you ever had, any of the following. Please check YES or NO.

	YES	NO	
Convulsions/Seizures			
Bleeding Tendency			
Acute Infection			
Hepatitis	___	___	Type:
Diabetes	___	___	On insulin?
Gestational Diabetes	___	___	Year:
Cancer	___	___	Year:
Specify type/location: _____			

15. SYSTEMS REVIEW

YES NO Explanation/Details

General

Good General Health
Recent Weight Changes
Fever

Eyes

Wear Glasses or Contacts
Past/Present Eye Disease
Transient Blindness

YES NO Explanation/Details

Ears/Nose/Mouth/Throat

Hearing Loss or Ringing
Chronic Sinus Problems
 or Rhinitis
Dentures
Nose Bleeds

Cardiovascular

Heart Attack
Chest Pain

If YES, did you see a doctor for it? YES ___ NO

Was it caused by:

Anxiety: YES __ NO __ Stomach/gallbladder: YES __ NO

Respiratory (asthma, emphysema): YES __ NO __ Don't know

Did you have tests or treatment for the chest pain? YES__ NO

Have you had a cardiac workup within the last year? If so, please give details:

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YES NO Explanation/Details

Cardiovascular (continued)

Shortness of Breath
with Exertion
Shortness of Breath
with Laying Flat
Swelling of Feet, Ankles,
Hands (please circle which)

YES NO Explanation/Details

Respiratory

Chronic or Frequent Cough
Spitting Up Blood
Asthma
Shortness of Breath
Past TB, Pneumonia, or
Valley Fever (circle which)

Gastrointestinal

Loss of Appetite
Change in Bowel Movements
Rectal Bleeding
Blood in Stool
Stomach Ulcer
Frequent Heartburn
Nausea or Vomiting
Liver Disease
Pancreas Disease
(not diabetes)

YES NO Explanation/Details

Genitourinary

Painful or Burning Urination
Difficulty Urinating
Blood in Urine
Kidney Stones
Testicular Pain
Irregular Periods
Infertility

History of Hysterectomy

Ovaries Removed

Urinary Incontinence

(can't hold urine)

YES NO Explanation/Details

Musculoskeletal

Joint Pain, Stiffness

Back Pain

Difficulty or Painful

Walking

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YES NO Explanation/Details

Integumentary (Skin)

Rash or Itching

Breast Pain

Breast Lump

Change in the Appearance
of a Breast

Nipple Discharge

YES NO Explanation/Details

Neurological

Frequent Headaches

Migraine Headaches

Dizzy/Lightheaded

How often?

Numbness/Tingling

Where? _____

Tremors

Stroke (Year ____)

Paralysis

Head Injury (Year ____)

Convulsions or Seizures

YES NO Explanation/Details

Endocrine

Hormone Problems

Thyroid Disease

Diabetes

Excessive Thirst or

Urination

Heat or Cold Intolerance

YES NO Explanation/Details

Hematologic/Lymphatic

Slow to Heal after Cuts

Bleeding Tendency

Bruising Tendency

Anemia

Blood Clots

Legs ___ Lungs ___

Past Blood Transfusion

16. The following is space for you to tell us anything we might have missed that you think we should know.

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17. How did you learn about us?

Another patient? (If so, give name):

From your doctor? (If so, give name):

Did you **first** learn about us through our website at “bariatricsurgeons.com”?

Did you **first** go to the internet website “obesityhelp.com”?

Other Internet/Web Site (write it in, if possible, or as much as you can remember):

Seminar (if so, write in month and year, if possible):

Newspaper: ___ Theater Advertisement: ___ Radio:

Other Advertisement? (please describe):

From your insurance company?

Other source:

18. Have you attended **our** bariatric seminar? YES ___ NO

Give month and year you did (or plan to) attend:

(You are **required to attend our** seminar before having surgery.)

DISABILITY FORMS, FLMA FORMS, etc.

Due to the time involved in filling out the variety of forms for disability, we require a fee of \$10. We do not have the forms in our office. We cannot promise same-day service, as most of these forms are several pages and require us looking up dates and medical codes. We cannot give these forms to you or send them in prior to your surgery. If you need a note or short letter to return to work, we will be happy to do that for you.

ADVANCED BARIATRIC CENTER PROGRAM

(FEE DUE AT TIME OF PREOPERATIVE VISIT)

This program includes protein samples, vitamins, a session with a Registered Dietitian, and a private session with a Certified Fitness Practitioner. You have access to 24-hour 7-day-a-week medical help from our physicians, as needed. Our support group is available either at monthly meetings or online if you live out of the area. We also have a newsletter online that has many helpful hints. Let us know if you are not online and this will be mailed to you. Once you have attended your preoperative appointment, the fee for the Bariatric Program will not be refunded under any circumstance, including your cancelling surgery. Your deposit should be in the form of cash, cashier's check, money order, Master Card, or Visa credit card. Please, no personal checks. This program is mandatory for all of our bariatric patients.

Hospitals and other surgery facilities often require prepayment of your insurance deductible. Please be prepared to make this payment before having surgery. You may call the hospital business office to make arrangements for payment.

BLUE SHIELD AND AFFILIATES OF BLUE SHIELD

Our office is non-preferred with Blue Shield and its affiliates. For information on your cost and financial responsibilities, please contact our business office.

I have given complete information in all parts of this Medical History Form to the best of my knowledge and have not knowingly omitted any information relating to my present or past health. I realize withholding or misstating medical information may be detrimental to my health and health care.

My signature below acknowledges my agreement to the terms described above.

YOUR NAME (PRINT)

YOUR SIGNATURE

DATE YOU COMPLETED THIS FORM _____

RISK FACTORS

Many of the risks and complications of this surgery are detailed in the booklet you received from our office. These are found under the headings "Serious and/or Life Threatening Complications," "Problems That are Usually Less Serious," and "Nuisance or Temporary Complications." They are summarized here, but review the booklet before signing below.

- Hair Loss** Many patients develop hair loss for a short period after the operation. This usually responds to increased vitamins and protein but can be permanent.
- Deficiencies** After gastric bypass there is malabsorption of many vitamins and minerals. Patients must take vitamin and mineral supplements forever to protect themselves from deficiencies. Supplements include, but are not limited to, multivitamins, calcium, and protein. Yearly blood tests must be done lifelong to detect and treat nutritional deficiencies.
- Pregnancy** Vitamin and mineral deficiencies in mothers who have had gastric bypass can impair normal fetal development. No pregnancy should occur for the first year after gastric bypass. It is important to know that fertility may increase during and following weight loss. Patients must inform their OB/GYN of their gastric bypass if they later become pregnant. Use of a dependable contraceptive immediately following surgery and for the first year is crucial.
- Laparoscopic Surgery Risks** Laparoscopic surgery uses punctures to enter the abdomen and can lead to injury, bleeding, or death. Other risks of this surgery include injury to the spleen, stapler malfunction, and the necessity to convert from a laparoscopic to an open procedure.
- Death** The risk of dying from Roux-en-Y gastroplasty is slightly less than 1%. As with any surgery, there is this risk.
- Driving, Prolonged Sitting** It is imperative that you have someone drive you when you are released from the hospital. Sitting puts you at risk for developing dangerous, even deadly, blood clots. You must get up every 30-40 minutes and walk for at least 10 minutes. You must also continuously sip liquids to avoid dangerous dehydration. Avoid movie theatres and long car rides for the first two weeks.
- Other** Any major abdominal surgery, including gastric bypass, is associated with a large variety of risks and complications, both recognized and unrecognized, that may occur both soon after or long after the operation. These include pneumonia, infection, blood clots, and leakage. Postoperative stenosis is not uncommon after this surgery and may require treatment. The occurrence of developing gallstones is increased with rapid weight loss.

By my signature below I accept and understand the possible risks and complications as mentioned above and in the booklet issued by Dr. Felix's office. I wish to proceed with my gastric bypass surgery.

Signature of Patient

Date

Blue Cross of California, Blue Shield of California,
TriCare, and all other insurances

MEMBER (PATIENT) RESPONSIBILITY AGREEMENT

This waiver form shall be used to document the mutual agreement between the Member and a participating healthcare professional/facility (Provider) for services, products, or upgrades that are deemed not medically necessary, or are considered not a covered expense under the Member's Benefit Agreement, but that the Member chooses to receive such services, products, or upgrades at his/her own expense.

To be effective and valid, this document must be executed prior to the delivery of any non-covered services, products, or upgrades.

MEMBER (PATIENT) NAME: _____ DOB: _____

PROVIDER: E.L. Felix, M.D., Inc. PROVIDER TAX I.D.: 77-0558944

PROVIDER PHONE: (559) 431-8446

MEMBER:

I AGREE TO PAY Provider for those services, products, or upgrades determined for the reason(s) specified below not to be covered under my Benefit Agreement:

- Not medically necessary
- Primarily for comfort and convenience
- Otherwise not a covered benefit or excluded under my coverage.

I understand that a participating Provider may not charge me for anything determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the Provider and/or I may appeal any determination of non-coverage by following the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage.

For the non-covered services, products, or upgrades listed below, I also understand that I am responsible for the difference between the covered expense for covered services and the Total Cost listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility. If the Total Cost of the service, product, or upgrade is not a covered expense, I understand that I am responsible for the Total Cost.

DATE OF SERVICE	SERVICE, PRODUCT, OR UPGRADE	TOTAL COST	MEMBER'S (PATIENT'S) RESPONSIBILITY
<u>TBD</u>	<u>Bariatric Pkg.</u>	<u>\$950.00</u>	<u>\$950.00</u>

*Member Responsibility is defined as cost of non-covered services, products, or upgrades. In addition to being responsible for the non-covered expense, I will be billed and held responsible for any co-pay, deductible, and/or coinsurance as stated in my Member's Benefit Agreement.

PATIENT SIGNATURE: _____ DATE: _____

To Our Patients:

Please have all the requested lab work, chest x-ray, and EKG done prior to your appointment. If there is a delay, please call our office to reschedule your appointment. Having to wait for results delays our ability to obtain authorization from your insurance company.

Your first appointment is a physical exam to go over any health issues you may have. If all your labs are acceptable and you need no further consultations, your request for surgery will be sent to your insurance company within 3 days of your initial visit. Expect to hear from us in 3-4 weeks. We will call as soon as we hear from your insurance company.

Every one of our patients is special to us and we are doing our best to get everyone on the surgical schedule as soon as it is safely possible. Please do not call to check if we have heard from your insurance company. Patients often receive news of authorization days before we do. As soon as we hear from your insurance company, we will contact you as soon as possible.

If you need special clearances from other physicians, we will contact you to let you know what is needed. It is your responsibility to get the results to our office so we can proceed in scheduling your procedure. We do not want to neglect the patients who are in our office, so please do not call to ask if we have received each fax.

We are an adult practice and request that you do not bring children to any of your appointments. While childhood diseases, colds, and flu may not harm children, they are very dangerous to a surgical patient. If you cannot arrange for a sitter, please reschedule your appointment. We appreciate your understanding.

We all look forward to helping you find a healthier new life. Thank you for choosing our practice.

Advanced Bariatric Center Staff