METABOLIC & BARIATRIC SURGERY OF FLORIDA

INFORMED CONSENT FOR **LAPAROSCOPIC ADJUSTABLE GASTRIC BAND** SURGICAL PROCEDURE

It is very important to Metabolic & Bariatric Surgery of Florida that you understand and consent to the treatment your surgeon is providing for you and any procedure your surgeon may perform. You should be involved in all decisions concerning surgical procedures your surgeon has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all your questions have been answered. Please sign and date directly below this paragraph indicating your understanding of this paragraph.

Patient signature or authorized representative: _____

Date: _____/_____/_____ Time: _____

I, _____, hereby authorize Joseph E. Chebli M.D. and any associates or assistants the surgeon deems appropriate, to perform Laparoscopic Adjustable Gastric Band surgery. The surgeon has explained to me the risks of obesity and the benefits of a Laparoscopic Adjustable Gastric Band; however, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, wellbeing, and safety.

YOUR CONDITION

I recognize that I am overweight with a weight of _____ lbs. at ____ft. _____ inches tall, and a BMI of _____. My surgeon or surgeons have clearly explained to me that this level of obesity has been shown to be unhealthy and that many scientific studies show that persons of this level of obesity are at increased risks of respiratory disease, high blood pressure, heart disease, high cholesterol, stroke, diabetes, arthritis, clotting problems, cancer, and death as well as other serious and less serious medical illnesses.

YOUR COMMITMENT

I am committed to long-term follow-up with my surgeon or surgeons and to make every effort to follow his/her directions to protect myself from these and other problems associated with Laparoscopic Adjustable Gastric Band surgery. I understand that to be effective, I need to make a life-long commitment to lifestyle changes, which may include, but are not limited to, dietary changes, an exercise program, and counseling. I understand that I will need to maintain proper nutrition, eat a balanced diet, and take vitamin and mineral supplements for the rest of my life. I will also be required to maintain follow-up medical care for my lifetime. Laboratory work will be required at least annually and perhaps more often, as directed by a physician.

YOUR PRE-OPERATIVE REQUIREMENTS

I have completed the Physician-Supervised Multidisciplinary Program, which included a nutritional visit (dietary therapy - a discussion of dietary history) by a licensed dietitian, along with a physician-supervised dietary therapy which included low calorie intake, physical activity, and behavior therapy support for either 3 months or 6 months prior to my scheduled surgery. Since the time of my initial evaluation to the date of surgery, I have either maintained or have lost weight.

YOUR POST-OPERATIVE REQUIREMENTS

Routine postoperative follow-up is crucial to a successful bariatric operation. We expect to follow you very closely for the first year and hopefully for the rest of your life. We encourage visits to the clinic for any problems that may arise in the postoperative period because we are best suited to handle them. I agree to participate in a post-surgical multidisciplinary program that includes diet, physical activity, and behavior modification.

YOUR PROPOSED PROCEDURE

I understand that the procedure that my surgeon(s) have recommended for the treatment of my obesity is the Laparoscopic Adjustable Gastric Band. My surgeon(s) have provided a detailed explanation of the medical history of the development of the surgical treatment of obesity, the gastric band as a treatment of obesity, the development of laparoscopic (minimally invasive) surgery and the Adjustable Gastric Band. I have been strongly encouraged to make every effort to investigate and understand the details of the operation.

I understand the nature of the Laparoscopic Adjustable Gastric Band will be done laparoscopically and entails the use of a fiberoptic endoscope along with special endoscopic instruments and staplers to facilitate completing the procedure with smaller incisions than in an open approach. It has been further explained to me that the laparoscopic approach to Adjustable Gastric Band surgery to treat morbid obesity is effective in achieving weight loss, improving comorbidities, and enhancing quality of life while reducing recovery time and perioperative complications. The Laparoscopic Adjustable Gastric Band procedure involves making several small incisions through which the surgeon(s) insert laparoscopic instruments to perform the surgery. I understand that the Laparoscopic Adjustable Gastric Band is an acceptable option as a primary bariatric procedure and as a first-stage procedure in high-risk patients as part of a planned staged approach.

RISKS & POSSIBLE COMPLICATIONS

The surgeon has explained to me that there are risks and possible undesirable consequences associated with a Laparoscopic Adjustable Gastric Band including, *but not limited to*:

- Abscess
- Adult Respiratory Distress Syndrome (ARDS)
- Allergic reactions
- Anesthetic complications
- Atelectasis
- Bleeding, blood transfusion, and associated risks
- Blood clots, including pulmonary embolus (blood clots migrating to the heart and lungs) and deep vein thrombosis (blood clots in the legs and or arms)
- Bile leak
- Bowel obstruction
- Cardiac rhythm disturbances
- Complications in subsequent pregnancy (pregnancy should not occur within one-year post surgery)
- Congestive heart failure
- Dehiscence or evisceration
- Depression
- Dumping syndrome
- Death.
- Encephalopathy
- Esophageal, pouch or small bowel motility disorders
- Gout
- Hernias, internal and incisional (including the port sites for laparoscopic access)
- Inadequate or excessive weight loss
- Infections at the surgical site, either superficial or deep including port sites for laparoscopic access. These could lead to wound breakdowns and hernia formation.
- Injury to the bowels, blood vessels, bile duct, and other organs
- Injury to adjacent structures, including the spleen, liver, diaphragm, pancreas, and colon
- Intestinal leak
- Kidney failure
- Kidney stones
- Loss of bodily function (including from stroke, heart attack, or limb loss)
- Myocardial infarction (heart attack)
- Need for and side effects of drugs
- Organ failure
- Perforations (leaks) of the stomach or intestine causing peritonitis, subphrenic abscess or enteroenteric or enterocutaneous fistulas
- Pleural effusions (fluid around the lungs)
- Pneumonia
- Possible removal of the spleen
- Pressure sores
- Pulmonary edema (fluid in the lungs)
- Serious intra-abdominal infection such as sepsis or peritonitis
- Skin breakdown
- Small bowel obstructions
- Staple line disruption
- Stoma stenosis
- Stroke
- Systemic Inflammatory Response Syndrome (SIRS)
- Ulcer formation (marginal ulcer or in the distal stomach)
- Urinary tract infections
- Wound infection

RISKS & POSSIBLE COMPLICATIONS

Nutritional complications include but are not limited to:

- Protein malnutrition
- Vitamin deficiencies, including B12, B1, B6, folate and fat-soluble vitamins A, D, E, K
- Mineral deficiencies, including calcium, magnesium, iron, zinc, copper, and others
- Uncorrected deficiencies can lead to anemia, neuro-psychiatric disorders, and nerve damage

Psychiatric complications include but are not limited to:

- Depression
- Bulimia
- Anorexia
- Dysfunctional social problem

Other complications include but are not limited to:

- Adverse outcomes may be precipitated by smoking
- Alopecia (hair loss)
- Anemia
- Bloating
- Bone disease
- Constipation
- Cold intolerance
- Cramping
- Development of gallstones
- Diarrhea
- Diminished alcohol tolerance
- Fatty liver disease or non-alcoholic liver disease (NALF)
- Intolerance of refined or simple sugars, dumping with nausea, sweating and weakness
- Low blood pressure
- Low blood sugar, especially with improper eating habits
- Loose skin
- Intertriginous dermatitis (rash between skin folds)
- Malodorous gas, especially with improper food habits
- Progression of pre-existing NALF or cirrhosis
- Stretching of the pouch or stoma
- Vitamin deficiencies some of which may have already existed prior to surgery
- Vomiting - inability to eat certain foods, especially with improper eating habits or poor dentition

Pregnancy complications were explained as follows:

- Pregnancy should be deferred 12-18 months after surgery or until weight loss is stabilized
- Vitamin supplementation during the pregnancy should be continued
- Extra folic acid should be taken for planned pregnancies
- Obese mothers have children with higher incidence of neural tube defects and congenital heart defects
- Pregnancy should be discussed with an obstetrician
- Special nutritional needs may be indicated or necessary
- Secure forms of birth control should be used in the first year after surgery
- Fertility may improve with weight loss

Furthermore, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. I also understand that some or all of the complications listed on this form and also explained to me may exist whether the surgery is performed or not, and that the Laparoscopic Adjustable Gastric Band surgery is not the only cause of these complications.

ALTERNATIVE PROCEDURES

In permitting my surgeon to perform the Laparoscopic Adjustable Gastric Band, I understand that unforeseen conditions may necessitate change or extension of the original procedure(s), including completing the operation by way of the conventional open surgical approach, or a different procedure from what was explained to me.

I therefore authorize and request that Joseph E. Chebli M.D., his assistants, or designees to perform such procedure(s) as may be necessary and desirable in the exercise of their professional judgment. In the unlikely event that one or more of the above complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address any concerns and questions.

The reasonable alternative(s) to the procedure(s), as well as the risks to the alternatives, have been explained to me. These alternatives include, *but are not limited to*, conversion to an open gastric band, Gastric Bypass, Vertical Banded Gastroplasty, Sleeve Gastrectomy, various diet exercise, drug treatments, or no surgery.

I understand that my surgeon will initially attempt to perform the Adjustable Gastric Band laparoscopically. If the procedure cannot be done laparoscopically, **I DO _____, DO NOT _____** wish for my surgeon to proceed with an open procedure. I hereby authorize the disposal of removed tissues resulting from the procedure(s) authorized above.

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

In the unlikely event that one or more of the above complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address any concerns and questions.

CERTIFICATION OF PATIENT

By signing below, I certify that I have had an opportunity to ask the surgeon all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all my questions have been answered to my satisfaction.

Date: _____/_____/_____ Time: _____

Signature of patient or authorized representative: _____

Relationship of authorized representative: _____

- ☐ The Patient/Authorized Representative has read this form or had it read to him/her
- ☐ The Patient/Authorized Representative states that he/she understands this information
- ☐ The Patient/Authorized Representative has no further questions

Date: _____/_____/_____ Time: _____

Signature of Witness: _____

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, material risks, alternative therapies, and the risks associated with the alternatives of the procedure(s).

Date: _____/_____/_____ Time: _____

Signature of Physician: _____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

IF APPLICABLE

An interpreter or special assistance was used to assist patient in completing this form as follows:

- ☐ Foreign language (specify) _____
- ☐ Sign language.
- ☐ Patient is blind, form read to patient.
- ☐ Other (specify) Interpretation provided by:

_____

(Fill in Name of Interpreter and Title or Relationship to Patient)

Date: _____/_____/_____ Time: _____

Signature of individual providing assistance: _____

PATIENT RESPONSIBILITIES

The purpose of this document is to ensure your understanding and commitment required to produce a successful outcome regarding your bariatric surgical procedure.

Instructions: Please read each paragraph, and once you agree to the contents of the paragraph, write your **initials on the line next to the paragraph**. If you have any questions as to the meaning of any paragraph, please ask for physician to explain it to you before signing.

_____ I understand that trust and confidence is necessary in a physician-patient relationship.

_____ I understand that if I do not follow through with all the terms of this documents that my physician may refuse to perform the procedure or may discharge me as a patient from the practice at any time.

_____ I understand that my care and treatment may include use of prescription drugs such as narcotics for pain control. I agree that if I misuse the drugs prescribed for me my physician may terminate my care and treatment. Misuse includes altering prescriptions, taking other than the prescribed dosage, or using fraudulent or illegal means to obtain drugs.

_____ I will fully communicate to my physician any concerns and will also communicate to my physician or other applicable healthcare provider any suspected complications after surgery.

_____ I agree to comply with the pre- and post-surgery protocols, which includes attending support group programs, following the diet(s) provided to me, and behavior modification.

_____ I agree to keep my follow up appointments as recommended by my surgeon and/or primary care physician.

_____ I agree to take my vitamins, calcium and other supplements for life as directed by my surgeon and/or primary care physician.

_____ I agree to have blood work done for life on an at least annual basis.

_____ I agree to see my surgeon and family physician as directed.

PATIENT RESPONSIBILITIES (continued)

_____ Any medical condition that exists or may develop, not in direct relationship to the bariatric surgery, must be treated by my primary care physician (and/or appropriate specialty physician), and I agree to coordinate my care with my surgeon. I understand that my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

_____ I understand that successful long-term weight loss is dependent on following the principles and guidelines of my surgeon's bariatric program.

_____ I verify that I have completed a medical history questionnaire and that to the best of my knowledge, it is true and correct.

I have read this form and discussed any questions that I have with my surgeon.

Date: _____/_____/_____ Time: _____

Patient Name (printed) _____

Patients Signature: _____

WITNESS:

□ The Patient/Authorized Representative has read this form or had it read to him/her.

□ The Patient/Authorized Representative states that he/she understands this information.

□ The Patient/Authorized Representative has no further questions.

Date: _____/_____/_____ Time: _____

Witness Name (printed): _____

Witness Signature _____

GUIDELINES FOR YOUR BARIATRIC SURGERY

NSAIDS

Nonsteroidal anti-inflammatory drugs have been linked to the cause of ulcers following weight loss surgery and should be avoided.

Examples of drugs to avoid include:

Advil, Aleve, Anaprox, Ansaid, Aspirin (Excedrin, Bufferin), Beta, Cataflam, Celebrex, Clinoril, Daypro, Feldene, Ibuprofen, Indocin SR, Lodine, Lodine XL, Motrin, Naprelan, Naprosyn, Orudis, Relafen, Tolectin, Toradol, Vioxx, and Voltaren.

Use of any of these medications must be discussed and approved by your surgeon.

STEROIDS

Oral Steroids are not permitted after surgery. Immunomodulators such as methotrexate, embrel, and humera must be discussed and approved by your surgeon. Avoid the use of intravenous steroids under any circumstances.

DIURETICS

Use caution when using diuretics (water pills). This is especially important in the early postoperative period when it can be more difficult to get in enough fluid. Please discuss with your surgeon.

TRAVEL

Long car trips, prolonged seating, and airline travel must be discussed with your surgeon if they occur within 30 days of surgery. These activities may put you at risk of developing blood clots.

HERBAL SUPPLEMENTS

Do not use fish oil, garlic, ginseng, ginkgo, or other herbal supplements within 2 weeks of surgery. They may all cause increased bleeding.

PREGNANCY

Forms of birth control such as oral pills, patches, injections, implants, or vaginal rings need to be stopped one month prior to surgery and should not be resumed until one month after surgery. Use extreme caution during this time and use reliable method of birth control to prevent pregnancy. The use of condoms, although not 100% effective, is the most reliable. A diaphragm is acceptable but must be continuously adjusted with weight loss.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

Witness Signature: _____

SMOKING POLICY

If you smoke, your bariatric surgeon will require you to stop smoking at least 8 weeks before your surgery. This is because patients who smoke are at a higher risk of having surgical complications, anesthesia complications and are more likely to develop pneumonia after surgery. Smoking also contradicts the purpose of bariatric surgery, which is about improving your overall health and quality of life.

We understand there are several reasons why it is difficult to stop smoking. Nicotine is the drug in tobacco products that causes dependence. Patients who smoke, even in moderation, are dependent on nicotine. Nicotine dependence is the most common form of chemical dependence in the United States. There are many health risks associated with smoking. Bariatric patients who have smoked for a long period of time fear gaining extra pounds once they quit smoking. We also understand that this is a time of stress because you are busy preparing for your upcoming surgery and anticipating the lifelong changes that follow. Regardless, we understand the effort involved but believe the risks of smoking are great and the benefits of smoking cessation far outweigh these inconveniences.

We want to help you reach your goals, so here are some tips:

Let us talk about *why* patients gain weight after they quit smoking.

- ***Changes in the metabolic rate***

Nicotine raises the metabolic rate; this temporarily slows after smoking cessation. Your body will burn off fewer calories, which causes the tendency to gain weight in some patients.

- *Changes in eating habits*

Patients are more inclined to eat sweet or fatty foods to eat more because food simply tastes better as taste buds reactivate.

- ***Oral cravings***

Many patients who have recently stopped smoking report that they miss the feeling of having something in their mouth. This could lead to snacking or mindless eating. Take advantage of the 8 weeks before surgery to adjust your eating and exercise habits:

- Discuss options for weight management with our dietician
- Discuss STOP SMOKING behavioral counseling with your counselor
- Discuss pharmaceutical options with your surgeon
- Get active!

We encourage you to access, download and review the American Cancer Society *Guide to Quit Smoking* and *Quit Smoking Tips* by searching:

- ACS Guide to Quitting Smoking
- ACS Quit Smoking Tips

Patient Signature: _____

ALCOHOL POLICY

I understand that immediately following bariatric surgery, I am to abstain from the use of alcohol for **one year.**

I (patient name) _____ have read and understand that alcohol metabolism after a gastric bypass may be altered and that my use of alcohol is voluntary. I understand that alcohol can be addictive and destructive to my health and may lead to accidents of unintended consequences. I have been fully informed of my increased relative risk and consequences of consuming alcohol after a gastric bypass.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

Date: _____/_____/_____ Time: _____

Witness Signature: _____

PREGNANCY CONTRACT

Understanding pregnancy, fertility, and bariatric surgery

Our Pregnancy Contact is provided to ensure that you fully understand that women of childbearing age who have had bariatric surgery must take special precautions in avoiding pregnancy for a designated period after weight loss. Weight loss due to bariatric surgery often increases fertility in those who have had difficulty conceiving in the past.

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statement.

_____ I understand that one of the goals of the Patient Contract is to help my bariatric team members understand that I commit to avoid pregnancy until discussed and cleared with my surgeon and obstetrician.

_____ I understand and agree that pregnancy should not be attempted until weight loss and nutritional intake have stabilized.

_____ As a woman of childbearing age who seeks bariatric surgery, I commit to using two reliable birth control methods during the period of rapid weight loss.

_____ I understand that maternal malnutrition may impair normal fetal development.

_____ When I become pregnant, I understand the importance of prenatal vitamins and other supplements and agree to take the prescribed amounts prior to and for the entire pregnancy as recommended by my dietician or obstetrician.

_____ I expect to delay pregnancy for at *least 18* months after surgery.

_____ I agree to discuss my procedure, the need for birth control, and my commitment to avoid pregnancy with my significant family members.

_____ When I become pregnant, I can expect that my surgeon and obstetrician will order special testing and treatments that could result in additional costs.

_____ I understand that I must stop all birth control (oral pills, patches, injections, implants, vaginal rings) one month before surgery and will not resume them until one month after surgery. Use extreme caution during this time and use reliable method of birth control to prevent pregnancy. The use of condoms, although not 100% effective, is the most reliable. A diaphragm is acceptable but must be continuously adjusted with weight loss.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

□ The patient/Authorized Representative has read the entire form or has had it read to him/her

□ The Patient/Authorized Representative express understanding of the form

□ The Patient/Authorized Representative has no further questions

Witness Signature: _____

PAIN MEDICATION POLICY

We at Metabolic & Bariatric Surgery of Florida support our patients as strongly and in as many ways as possible. We know that wounds from surgery can be painful. Most bariatric surgery patients will use narcotic pain medications post operatively, for a limited time.

It is our policy to limit post-operative pain medication to those prescribed at the time of discharge. Florida State Law prohibits prescribing narcotic pain medication over the phone. Our practice is not intended to manage a patient's pain on a long-term basis, and we refer patients in need of long-term pain management or pain management needed that does not arise from our procedure to a pain management specialist.

THERE CAN BE NO EXCEPTIONS TO THIS POLICY.

Furthermore, you should be aware of Florida's prescription monitoring program that tracks pain medication prescriptions written by physicians and prescriptions filled. Florida implemented this program as part of its efforts to impact prescription pain medication abuse. Metabolic & Bariatric Surgery of Florida is committed to compliance with these requirements. If a patient has had issues with severe pain previously associated with medical care, we recommend evaluation by a pain specialist prior to any planned procedure. We would be happy to refer you to a local pain management specialist should you be interested in this option. For those patients who are already under the care of a pain management specialist, we recommend that you contact them prior to surgery to inform them of your scheduled bariatric procedure. We welcome recommendations from your specialist for *in hospital* care and will defer to your specialist on your best method of pain control post operatively. We do request that they send us instructions for your specific care, and that they prescribe your medications after discharge to avoid confusion.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

SPOUSAL AGREEMENT

I, (spouse name) _____, am presently married to

(patient name) _____. I understand my spouse wishes to undergo bariatric surgery. I have been actively involved in and fully support my spouse's decision to undergo bariatric surgery.

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statements:

_____ I have been fully informed of the nature of bariatric surgery.

_____ I fully understand that the surgery that my spouse will undergo will require a lifelong commitment, including changes in diet and behavior modifications.

_____ I also understand that the bariatric surgery involves dangers and risks including, but not limited to: post-operative infection, leaks, death, depression, emotional changes and other physical and psychological changes all of which I fully understand.

_____ I understand that because of this surgery, my spouse may lose a significant amount of weight, changing his/her appearance.

I have no further questions or concerns to discuss currently. However, if I do have questions in the future, I have been encouraged by the bariatric team to ask.

It is with my full knowledge and consent that my spouse undergoes bariatric surgery.

Date: _____/_____/_____ Time: _____

Spouse Name (printed): _____

Spouse Signature: _____

Date: _____/_____/_____ Time: _____

Witness Name (printed): _____

Witness Signature: _____

ADVOCATE SUPPORT AGREEMENT

Can also be completed by significant other

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statements:

I, (advocate name) _____, understand that

(patient name) _____ wishes to undergo bariatric surgery.

_____ I have been fully informed of the nature of bariatric surgery.

_____ I have been actively involved in and fully support Patient's autonomous decision to undergo bariatric surgery.

_____ I fully understand that bariatric surgery involves dangers and risks including, but not limited to, post-operative infection, leaks, death, depression, and physical and psychological and emotional changes that are listed on the informed consent, which I have read and understand fully.

_____ I understand that because of this surgery, the patient may lose a significant amount of weight, changing his/her appearance.

_____ I fully understand that the surgery which patient will undergo requires a lifelong commitment to behavioral changes which could include changes in eating habits, emotional coping skills and more.

I have no further questions or concerns to discuss currently. However, if I do have questions in the future, I have been encouraged by the bariatric team to ask.

It is with my full knowledge and agreement that the patient undergoes bariatric surgery.

Date: _____/_____/_____ Time: _____

Advocate Name (printed): _____

Advocate Signature: _____

Date: _____/_____/_____ Time: _____

Witness Name (printed): _____

Witness Signature: _____

PROTEIN AND VITAMIN SUPPLEMENT POLICY

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statements:

_____ I understand the Adjustable Gastric Band is both malabsorptive and restrictive; if I do not take the recommended vitamin/mineral supplements, I may develop vitamin/mineral deficiencies.

_____ I understand that my bariatric surgery team may ask me to keep a food journal/diary to help assess nutritional problems, protein/vitamin intake or disordered eating behavior.

_____ I can expect nutritional lab work to be done at least annually for the rest of my life. It is my responsibility to complete my lab orders as directed.

_____ I understand the importance of a balanced diet including protein which promotes satiety (fullness) and protects muscle mass during active weight loss.

_____ I agree to take the recommended vitamin/mineral supplementation regimen recommended by my bariatric surgery team which typically includes multivitamin, vitamin B12, calcium citrate, vitamin D, (and others as indicated by deficiencies found on my lab work).

_____ I agree to continue these new eating habits and behaviors I learned prior surgery to optimize my weight loss and nutrition. I will continue to choose these new healthier eating habits for life.

_____ If my lab work shows vitamin/mineral deficiencies before surgery, I may need to repeat these levels before having surgery to optimize my health.

_____ It is my responsibility to ask questions when I am uncertain about vitamins and protein supplements.

_____ I understand that if I fail to accept my responsibility for care as directed by my bariatric surgery team, I could be terminated from their care.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

□ The patient/Authorized Representative has read the entire form or has had it read to him/her

□ The Patient/Authorized Representative express understanding of the form

□ The Patient/Authorized Representative has no further questions

Date: _____/_____/_____ Time: _____

Witness Signature: _____

PROTEIN AND VITAMIN SUPPLEMENT TEST

Please indicate if the statement is true or false by circling your answer:

TRUE OR **FALSE** 1. Adjustable Gastric Band is both malabsorptive and restrictive.

TRUE OR **FALSE** 2. Malabsorption is not typically a problem after laparoscopic adjustable band.

TRUE OR **FALSE** 3. I understand that I am expected to keep food diaries because they help assess nutritional problems, protein/vitamin intake or disordered eating behaviors.

TRUE OR **FALSE** 4. I can expect lab work to be done annually, and it is my responsibility to have this done as directed.

TRUE OR **FALSE** 5. I understand the importance of protein to health and recognize poor protein intake could lead to hair loss.

TRUE OR **FALSE** 6. The malabsorptive and restrictive nature of gastric bypass predisposes me to protein and vitamin deficiencies.

TRUE OR **FALSE** 7. I agree to take B-complex and chewable calcium as directed daily.

TRUE OR **FALSE** 8. Attention to protein and vitamin supplement begins before surgery and continues for life.

TRUE OR **FALSE** 9. I agree to take thiamine supplements along with a quality multivitamin each day as directed by my healthcare team.

TRUE OR **FALSE** 10. Some patients are protein/vitamin challenged before surgery, and therefore dietary education and nutritional changes must occur even before surgery.

TRUE OR **FALSE** 11. It is my responsibility to ask questions when I am uncertain about vitamins and protein supplements.

TRUE OR **FALSE** 12. I understand that if I fail to accept my responsibility for care as directed by my physician's team, I could be terminated from care.

Date: _____/_____/_____ Time: _____

Patient Signature: _____

□ The Patient/Authorized Representative has read the entire form or had it read to him/her.

□ The Patient/Authorized Representative has express understanding of this form.

□ The Patient/Authorized Representative has no further questions.

Date: _____/_____/_____ Time: _____

Witness Signature: _____

BARIATRIC PATIENT EXAM

This exam is to review the information that you have been provided thus far. The purpose is to have a completed written evaluation of your knowledge and an assurance that you are fully educated on the subject. We will review, correct, explain, or clarify any incorrect answers.

Please indicate if the statement is true or false by circling your answer:

TRUE OR **FALSE** 1. The success of bariatric surgery depends on my long-term commitment to the provided dietary, activity and medical guidelines.

TRUE OR **FALSE** 2. I may not lose all the weight I had hoped to lose from bariatric surgery.

TRUE OR **FALSE** 3. Having bariatric surgery will commit me to regularly scheduled follow-up visits with my physician.

TRUE OR **FALSE** 4. It is necessary that I take prescribed vitamins after surgery for the rest of my life.

TRUE OR **FALSE** 5. After this surgery, it is possible that I may experience diarrhea and cramping especially after eating too much, too fast or the wrong kinds of foods.

TRUE OR **FALSE** 6. Individuals who have bariatric surgery find that all their comorbidities have been resolved.

TRUE OR **FALSE** 7. It is not advisable to be pregnant at the time of surgery or to become pregnant in the first eighteen months after surgery.

TRUE OR **FALSE** 8. There has not been a patient who has ever gotten seriously depressed after surgery.

TRUE OR **FALSE** 9. There is a possibility I could require short or long-term intensive care in the hospital after bariatric surgery.

TRUE OR **FALSE** 10. Re-operation may be necessary due to bleeding, hernias, ulceration, separation of stitches or staples, leakage, blockage of the intestines or other causes.

BARIATRIC PATIENT EXAM (continued)

TRUE OR **FALSE** 11. Clots may form in my legs or pelvis, which can break off and float into the lungs. These can cause shortness of breath or chest pain that can be fatal.

TRUE OR **FALSE** 12. In the hospital following surgery, patients are expected to get out of bed and walk as soon as possible.

TRUE OR **FALSE** 13. There is a possibility that I may feel depressed for a short amount of time post-surgery.

TRUE OR **FALSE** 14. To achieve and maintain weight loss goals, it is recommended that most days of the week I exercise daily for 30 minutes.

TRUE OR **FALSE** 15. If I eat foods high in calories or high in sugar, I may experience a "*dumping syndrome"* which can cause stomach pouch pain, nausea, vomiting, increased heart rate, and a near fainting feeling.

TRUE OR **FALSE** 16. Once I reintroduce "regular foods" to my diet, I will still need to limit high fats and high sugar foods long-term.

TRUE OR **FALSE** 17. After bariatric surgery, I have been guaranteed to permanently lose weight.

TRUE OR **FALSE** 18. After I recover from bariatric surgery and go home, I should just be patient with any medical problems I may experience and not call my bariatric surgery team for at least 2-3 days.

TRUE OR **FALSE** 19. After surgery I may experience a feeling of grief over the loss of my relationship with food.

TRUE OR **FALSE** 20. Diabetes, high blood pressure, back pain, and similar ailments may improve after bariatric surgery.