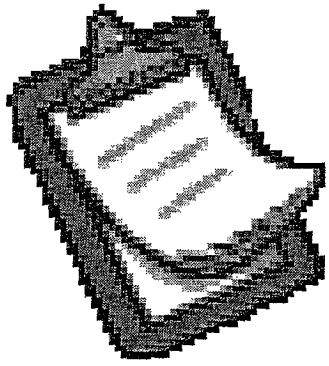
New Patient Packet

Please Complete the Following Packet Prior to Your First Appointment.

If you do not complete prior to your appointment it may result in being asked to reschedule.

Please arrive 30 min prior to your appointment.

Thank You



Advanced Bariatric Services
2235 Cedar Lane, Suite 101, Vienna, VA 22182 Tel (703) 778- **6000** Fax (703) 778-6005

HAZEM A. ELARINY, MD, PhD,

Thank you for choosing Dr. Elariny as a potential surgeon. We hope your experience with us is informative, beneficial and comfortable. When you come for your visit, please bring a copy of your insurance card and a photo ID. Any medical background that can be provided regarding your diet history or co-morbidities that can be attributed to your weight would be helpful in your insurance approval process. Your appointment times are listed below. Should you need to reach us or cancel any of the appointments please register online at www.ALAGSA.com appointments and make changes there or call the office at 703-778-5050. (Please cancel more than 2 business days ahead of your appointment time.)

Bariatric Discussion Group_____
From 5:00 pm-8:00 pm
At the Physicians Conference Center, in the 2nd floor in the Auditorium at
INOVA Fairfax Hospital
3300 Gallows Rd.
Falls Church, VA 22042

OR

From 6:30 pm – 9:30 pm
At the Seminar Conference Room
3700 Joseph Siewick Dr.
Fairfax, VA 22033

If after you attend the discussion group you choose to proceed with the following appointments, when you come in to your first office appointment, we will be collecting co-pay by cash or check. No credit / Debit cards accepted.

Nutritional Consultation on_____
2235 Cedar Lane, Suite 101
Vienna, Virginia 22182

Consultation with Physician's Assistant on_____
(Same address as Nutrition Consultation and meeting with the doctor)

Individual Consultation with MD on_____
2235 Cedar Lane, Suite 101
Vienna, Virginia 22182

The program fee will vary depending upon the type of procedure chosen and will be collected when your insurance company approves your procedure.

A.L.A.G.S.A.
2235 Cedar Lane, Suite 101
Vienna, VA 22182
Telephone# 703-778-6000
Fax# 703-778-6005

DIRECTIONS TO TEE OFFICE FROM THE WEST

Interstate 66	Take 166 East towards DC Take the exit for Leesburg Pike (Rte 7) West towards Tyson's Corner Make a left onto Gallows Road Follow Gallows Road about 1-2 miles south Make a right between the Mobil and Sunoco gas stations onto Cedar Lane. 2235 is ¼ mile down on your left

DIRECTIONS TO THE OFFICE FROM ROCKVILLE / BALTIMORE

Beltway 495	Heading south on 495, Take the Leesburg Pike exit (Rte 7) towards Tyson's Corner Make a left onto Gallows Road (International BLVD) Follow Gallows Road about 1-2 miles south Make a right between the Mobil and Sunoco gas stations onto Cedar Lane. 2235 is ¼ mile down on your left

DIRECTIONS TO THE OFFICE FROM THE SOUTH

I 95 North	Take 195 North to 495 West towards Tyson's Corner Take the Gallows Road exit, Make a Left onto Gallows Road Follow Gallows road for 2-3 miles Make a left between the Mobil and Sunoco gas stations onto Cedar Lane. 2235 is ¼ mile down on your left
Southern MD	Take I 95 / 495 south towards Richmond Follow *495* around towards Tyson's Corner Take the Gallows Road Exit, Make a Left onto Gallows Road Follow Gallows road for 2-3 miles Make a left between the Mobil and Sunoco gas stations onto Cedar Lane. 2235 is ¼ mile down on your left

DIRECTIONS TO THE OFFICE FROM DC

I66 West	Take I66 West to the Leesburg Pike exit (Rte 7), towards Tyson's Corner Make a Left onto Gallows Road Follow Gallows Road about 1-2 miles south Make a right between the Mobil and Sunoco gas stations onto Cedar Lane. 2235 is '/4 mile down on your left

Advanced Laparoscopic & General Surgery Associates
(ALAGSA)
HAZEM A. ELARINY, MD

Request for Medical Records / Release of Information Form

The undersigned patient or patient representative agrees to the following terms regarding all general and specific information transmission, and/or requests that specified medical records be delivered to the specified location via the specified modality. I understand that a fee may apply for specific requests.

Patient's Name: _____ EMAIL: _____
Patient's Date of Birth: _____ Private Fax: _____

Records requested: ANY RECORDS DEEMED NECESSARY FOR THE PRE-OPERATIVE AND POSTOPERATIVE EVALUATION AND MANAGEMENT OF PATIENT'S CASE. RECORDS MAY BE SENT TO REFERRING PHYSICIANS, SPECIALISTS, HOSPITALS, PRE-OP CENTERS, INSURANCE OR FINANCING AGENCIES OR OTHER ENTITIES, PERSONS, OR PROFFESIONALS THAT NEED SUCH INFORMATION FOR THE PATIENT'S CARE OR FOR FINANCIAL PURPOSES. Modality of record delivery may include phone conversation, fax, email, US Mail, UPS, FedEx, or other courier. I understand that any of these delivery modalities is not perfect and that the records may reach persons or entities other than those requested either because of modality or human error. I understand that ALAGSA and its employees are acting in good faith and I certify that I will indemnify and hold ALAGSA and its employees harmless for any such delivery error or its consequences.

<table>
<tr><td colspan="2">If you are requesting specific records please complete the following:</td></tr>
<tr><td colspan="2">Specific records requested: (Write "none" if no records currently requested)</td><td rowspan="4">Circle Method:

Email
Phone
Fax: (Free to 10 pages, then 10c/page)
US Mail ($0.40 + 10c/page)
FedEx ($0.40 + 10c/page) + FedEx fee
Express Mail ($3.00 + 10c/page) + Express Mail Fee
(NO PO BOX ADDRESSES for FedEx)</td></tr>
<tr><td>Recipient name:</td><td rowspan="2">Recipient Address:</td></tr>
<tr><td>Fax Number:</td></tr>
<tr><td>Phone Number</td><td>Email Address:</td></tr>
</table>

I agree to receive email/faxes regarding my medical condition from my doctor or ALAGSA. I understand that when I communicate via email, that response times may be significantly slow and delayed and that I will not depend on this modality for time sensitive communications or urgent problems.

_____ _____ _____
Patient's Printed Name Today's Date Patient Signature

OR
I certify that I am legally entitled to sign on behalf of the above-identified patient.

_____ _____ _____
Representative Printed Name Today's Date Patient Representative Signature

I certify that I am legally entitled to sign on behalf of the above-identified patient.

Updated 10-7-2000 (HAE)

ADVANCED BARIATRIC SERVICES
HAZEM A. ELARINY, MD
2235 Cedar Lane, Suite 101
Vienna, Va 22182
Telephone (703) 778- 6000 Fax (703) 778-6005

NEW PATIENT'S INFORMATON SHEET

PATIENT INFORMATION

Name (First):_____(M)_____(Last)_____
Date of Birth:_____Age:_____ Sex ☐Male ☐Female Marital Status ☐S ☐M ☐W ☐D
Social Security#_____ Home Phone# (___)_____ Cell Phone# (___)_____
Address (Street)_____APT#_____
City_____State_____Zip_____
Employer_____Work Phone# (_____)_____
Employer's Address_____
Referring Physician_____Patient's Email_____
Emergency Contact_____Phone# (_____)_____
Relationship_____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Full Name_____Relationship To Patient_____
Address (Street)_____APT#_____
City_____State_____Zip_____
Phone# (_____)_____Social Security#_____Email_____
Employer_____Work# (___)_____Cell# (___)_____
Employer's Address_____

INSURANCE INFORMATION

Medicare#_____Medicaid#_____
Insurance Co._____Phone# (_____)_____
Insurance Address_____City_____State_____Zip_____
Certificate or ID#_____Group#_____
Insured's Name_____Relationship to Patient_____
Insured's Employer_____Phone# (_____)_____
Employer's Address_____City_____State_____Zip_____
Insured's Social Security#_____Date Of Birth_____ Sex ☐M ☐F

I attest that the above information is true and accurate. I have read the Authorization and Services Provision Agreement and Agree to its terms and conditions.

X_____ X_____

Signature of Patient OR Authorized Agent Date Signed

ADVANCED BARIATRIC SERVICES
HAZEM A. ELARINY, MD
2235 Cedar Lane, Suite 101
Vienna, VA 22182
Telephone (703) 778- **6000** *Fax (703) 778-6005*

Authorization and Service Provision Agreement

I AUTHORIZE ADVANCED LAPAROSCOPIC & GENERAL SURGERY ASSOCIATES, P.L.L.C. AND ITS PHYSICIANS AND EMPLOYEES (ABS) TO PROVIDE PROFESSIONAL MEDICAL SERVICES TO PATIENT OR MYSELF.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.

I REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ANY PHYSICIAN AND OR HEALTH CARE PROFESSIONAL ASSOCIATED WITH ALAGSA WHO ENGAGES IN MY CARE.

IN THE EVENT I AM A MEMBER OF A MANAGED CARE ORGANISATION (MY MCO) THAT ALAGSA PROVIDERS CONTRACT WITH, ALAGSA PROVIDER AGREES TO FILE A CLAIM ON MY BEHALF TO MY *MCO* FOR PAYMENT ONLY FOR COVERED OR CONTRACTED SERVICES.

IN THE EVENT THAT AN ALAGSA PROVIDER IS NOT A PARTICIPATING PROVIDER IN MY MCO, I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES RENDERED. SHOULD MY ACCOUNT BE TURNED OVER TO COLLECTIONS DUE TO NON PAYMENT, I WILL BE RESPONSIBLE FOR ANY COLLECTION AND ATTORNEY FEES.

IN THE EVENT I AM A MEMBER OF MCO THAT ALAGSA PROVIDER CONTRACTS WITH BUT I AM UNDERGOING A NON-COVERED OR NON-CONTRACTED SERVICE, I AM RESPONSIBLE FOR PAYMENT IN FULL FOR EACH AND ALL SERVICES RENDERED AND I WAIVE MY RIGHTS UNDER ANY MCO AGREEMENT TO WHICH I AM A MEMBER AND I AGREE TO HOLD HARMLESS AND INDEMNIFY PROVIDER AGAINST ANY CLAIM THAT ARISES IN SUCH CIRCUMSTANCE AGAINST PROVIDER.

IN THE EVENT I AM A MEMBER OF MCO THAT ALAGSA PROVIDER CONTRACTS WITH BUT I AM UNDERGOING A NON-COVERED OR NON-CONTRACTED SERVICE OR A SERVICE FOR WHICH A DENIAL OF BENEFITS FIAS BEEN ISSUED BY MY MCO, I AM RESPONSIBLE FOR PAYMENT 114 FULL FOR EACH AND ALL SERVICES RENDERED EVEN IF SUCH NON-COVERED OR NON-CONTRACTED SERVICE OR DENIED BENEFIT BECOMES COVERED OR BECOMES AN APPROVED BENEFIT AFTER PROVISION OF SAME SERVICE AND I WAIVE MY RIGHTS UNDER ANY *MCO* AGREEMENT TO WHICH I AM A MEMBER AND I AGREE TO HOLD HARMLESS AND INDEMNIFY PROVIDER AGAINST ANY CIATh4 THAT ARISES IN SUCH CIRCUMSTANCE AGAINST PROVIDER.

IN THE EVENT I HAVE SUPPLIED INNACURATE OR INCOMPLETE INSURANCE INFORMATION OR I HAVE NOT SUPPLIED INSURANCE INFORMATION OR I HAVE SUPPLIED PRIMARY INSURER AS SECONDARY INSURER OR SECONDARY INSURER AS PRIMARY, I AM RESPONSIBLE FOR PAYMENT 114 FULL AND I WAIVE MY RIGHTS UNDER ANY MCO AGREEMENT TO WHICH I AM A MEMBER AND I AGREE TO HOLD HARMLESS AND INDEMNIFY PROVIDER AGAINST ANY CLAIM THAT ARISES IN SUCH CIRCUMSTANCE AGAINST PROVIDER.

I HEREBY AUTHORIZE ALAGSA AND PROVIDERS TO RELEASE ANY AND ALL MEDICAL INFORMATION NECESSARY IN THE COMPLETION OR PERFECTION OF A CLAIM OR IN THE PERFORMANCE OF CONTRACTUAL OR GOVERNMENTAL OR OTHER LEGAL OR PROFFESSIONAL OBLIGATIONS TO ANY AND ALL INSURANCE COMPANIES AND/OR OTHER RELATED OR GOVERNMENTAL OR PROFFESSIONAL ENTITIES.

I HEREBY AUTHORIZE ALAGSA AND PROVIDERS TO INCLUDE DATA DERRWED FROM MY CARE OR CASE IN INTERNAL AND EXTERNAL PRACTICE REVIEWS AND/OR INTO REVIEW OR SUMMARY STATEMENTS AND/OR INTO ABSTRACTS OR PUBLICATIONS AS LONG AS SUCH REVIEWS/ABSTRACTS/SUMMARIES/PUBLICATIONS DO NOT CONTAIN IDENTIFYING INFORMATION.

I HEREBY AUTHORIZE THAT PAYMENT OF ANY MEDICAL BENEFITS BE MADE DIRECTLY TO ALAGSA OR THE PROVIDER.

IF I AM A MEDICARE PATIENT, I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE TO ALAGSA AND OR PROVIDER FOR ANY SERVICES FURNISHED TO ME BY ALAGSA PROVIDER(S).

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

THIS AUTHORIZATION WILL REMAIN EFFECTIVE FOR THE CURRENT CONDITION AND ANY SUBSEQUENT CONDITIONS OR CARE AND IS NON-REVOKABLE EXCEPT THROUGH MY REFUSAL TO ACCEPT FUTURE SERVICES. ANY ACCEPTANCE OF SERVICES UPON MYSELF OR PATIENT BY ALAGSA IS IPSO FACTO AND BY DEFAULT A REAFFIRMATION OF THIS AUTHORIZATION STATEMENT.

X X

Signature of Patient OR Authorized Agent Date Signed

ADVANCED BARIATRIC SERVICES

2235 Cedar Lane, Suite 101, Vienna, VA 22182 Tel (703) 778-5050 Fax (703) 778-6005

NEW PATIENT QUESTIONAIRE

Date Completed by Patient: __/____/_____ Date of Visit: _____/____/_____

Questions:	Yes, No or Not applicable. Circles one if appropriate	Write in the Other Answers and Doctor's Comments:
Please print patient's name:		
Patient's date of birth		Height: Weight:
Patient's SSN#		
Who is filling out this form?		
What is the main reason you are here today to see the surgeon?		
When did the problem start?		
Do you have pain?		
Where is the pain?		
How often is the pain?		
Does it get better, than worse in cycles?		
What other doctor(s) have you seen about this?		
Please provide whatever details you think are important:		

Have you had any of the following complaints or Diagnoses? Circle the ones you have. Write in anything else not listed. Please describe more detail on the right column.

SYSTEM	SYMPTOM / COMPLAINT	DIAGNOSES CONDITIONS YOU HAVE	COMMENTS
CONSTI-TUTIONAL	o FEVER o WEIGHT LOSS o NIGHT SWEATS o SLEEPY OR TIRED ALL DAY o FATIGUE o LOSS OF APPETITE	o Fibromyalgia	
EYES	o CHANGES IN VISUAL ACUITY o NOTICEABLE JAUNDICE	o Cataracts	

ENMT	o CHANGES IN HEARING o RHINORRHEA (NOSE DISCHARGE) o ULCERS OR LUMPS IN YOUR MOUTH o SORE THROAT o THRUSH	o SLEEP APNEA	
RESPIRA-TORY	o COUGH o SHORTNESS OF BREATH o HEAVY SNORING o AWAKING FEELING YOU ARE SUFFOCATING	o Pulmonary Hypertension o Asthma	
CARDIO-VASCULAR	o LEFT-SIDED SUBSTERNAL CHEST PAIN o SHORTNESS OF BREATH o LEG OR ANKLE SWELLING o CLAUDICATION (LEG CRAMPING) o PAIN IN CALF OR BUTT WHEN YOU WALK o LOWER EZTREMITY VARICOSITIES o VENOUS STASIS SYMPTOMS o ULCERS ON YOUR FEET	o Coronary Artery Disease o Pulmonary Embolism o Hypertension	
GASTRO-INTESTINAL	o ABDOMINAL PAIN o BLOATING SENSATION o HEARTBURN o INDIGESTION o DIARRHEA o CONSTIPATION o NAUSEA o VOMITING o MELENA (BLACK STOOLS) o HEMATOCHEZIA (BLOODY STOOLS) o HEMATEMESIS (VOMITING BLOOD) o PAIN ON HAVING BOWEL MOVEMENTS o FOOD GETTING STUCK IN FOOD PIPE	o GERD o Gastritis o Diverticulitis o Liver cirrhosis o Crohn’s disease o Ulcerative Colitis	
GENITO-URINARY	o VAGINAL DISCHARGE o VAGINAL BLEEDING o DSURIA (DIFFICULT URINATION) o FREQUENCY o BLOODY URINE o STRESS URINARY INCONTINENCE	o Stress Urinary Incontinence o Kidney Stones	

MUSCULO-SKELETAL	o MUSCULAR WEAKNESS o REDUCED RANGE OF MOTION (KNEES AND BACK) o ARTHRITIC PAINS	o Gout o Osteoarthritis o Rheumatoid Arthritis	
INTEGU-METARY	o SKIN LESIONS o ITCHING o ULCERS o BREAST LUMPS o MASSES	o Psoriasis	
NEURO-LOGICAL	o WEAKNESS OF AN ARM OR LEG o NUMBNESS OF AN ARM OR LEG o TRANSIENT VISUAL LOSS	o Stoke o AML	
PSYCHIATRIC	o SUICIDAL IDEATION o SIGNIFICANT SOCIAL STRESS	o Depression	
ENDOCRINE	o FEELING COLD ALL THE TIME o FEELING HOT ALL THE TIME o FREQUENCY / SWEET – SMELLING URINE o HEADACHES	o Hypothyroid o Diabetes o High Cholesterol o High Triglycerides	
HEMATO-LOGIC / LYMPATIC	o NECK LUMPS o SUPERACLAVICULAR LUMPS o GROIN FATIGUE	o Lymphoma	
ALLERGIC / IMMUNO-LOGIC	o CHRONIC SINUS ALLERGY o GENERAL SENSITIVITIES		

Do you have any other medical history the doctor should be aware of?	Yes No N/A	
Do you have any history of MRSA?	Yes No N/A	
Have you ever had total parenteral nutrition or TPN?	Yes No N/A	
Have you ever been hospitalized for reasons other than surgery? <u>If so list why, and which hospital?</u>	Yes No N/A	
What medicines do you take regularly? Please provide the dose and how often:	Yes No N/A	

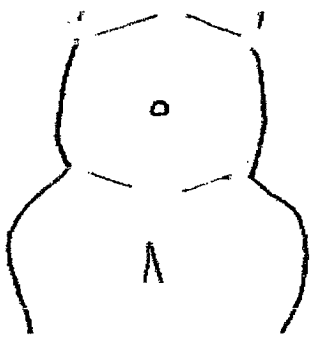
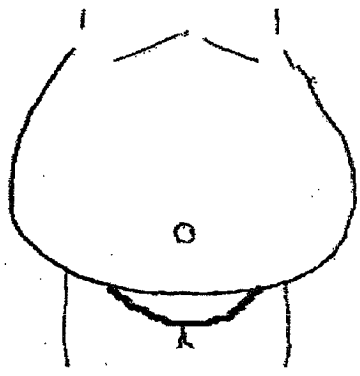
Do you or have you ever taken the following medications?	Yes No N/A	Steroids / Estrogens / Amiodarone / Perhexiline / Nifedipine
What allergies do you have? Medication / food / latex / other	Yes No N/A	
What surgeries, injuries, operations, and/or fractures have you had in your life? Circle those that apply and add those not listed. Where do you have surgical scars?	Yes No N/A	Tonsillectomy / Appendectomy / Gallbladder / Hysterectomy (complete / partial / vaginal) / Stomach Surgery
What diseases have your relatives had?	Yes No N/A	Example: Breast Cancer, Colon Cancer, Heart Attack, Stroke, Obesity, Diabetes, Hypertension, etc.
Father:	Yes No N/A	
Mother:	Yes No N/A	
Brother:	Yes No N/A	
Sister:	Yes No N/A	
Children:	Yes No N/A	
How many children do you have? What are each of their ages?	Yes No N/A	
Do you smoke tobacco? When did you start?	Yes No N/A	
When did you quit?	Yes No N/A	
How many packs of cigarettes per day do/did you smoke?	Yes No N/A	
If you still smoke, do you promise to quit today?	Yes No N/A	
Do/did you chew tobacco?	Yes No N/A	
When did you drink the most in your life? How much beer or liquor do/did you drink per day? How many years?	Yes No N/A	
How much do you drink now?	Yes No N/A	

Have you ever had your Colon checked? How? When?	Yes No N/A	Date:	Results:
When was your last chest X-ray?	Yes No N/A	Date:	Results:
When was your last EKG?	Yes No N/A	Date:	Results:
MEN: When was your last PSA (Prostate Specific Antigen) checked?	Yes No N/A	Date:	Results:
MEN: When was your last prostate exam?	Yes No N/A	Date:	Results:
MEN: Do you know about self-testicular examination?	Yes No N/A		
WOMEN: When did you have our first menstrual period?	Yes No N/A	Age:	
WOMEN: When was your last, most recent menstrual period?	Yes No N/A	Date:	Heavy / Normal / Light
WOMEN: Have you ever been on Hormones or Birth control pills? What type and how long?	Yes No N/A		
WOMEN: Did you breastfeed your newborns? How many? How long?	Yes No N/A		
WOMEN: When was your last GYN visit and PAP-smear?	Yes No N/A	Date:	Results:
WOMEN: When was your last mammogram?	Yes No N/A	Date:	Results:
WOMEN: Do you know about self-breast examination?	Yes No N/A		
What blood tests have you had in the past 6 months, and what were the results?	Yes No N/A		
what X-rays have you had in the past 6 months, and what were the results?	Yes No N/A		
Do you have any specific questions you expect answered today? What are they?	Yes No N/A		

DOCTOR'S EXAMINATION FORM:

(PLEASE PLACE A STAR NEXT TO ANY PART OF THE EXAM YOU WISH TO DISCUSS BEFORE EXAMINATION OR YOU WISH NOT TO HAVE.)

Patients Name:_____ **DOB:**_____

PHYSICAL EXAMINATION	**DATE OF PHYSICAL** _____/_____/_____			
HEIGHT			TEMPERATURE	
WEIGHT			PULSE	
BODY MASS INDEX		WAIST TO HIP RATIO:	BLOOD PRESSURE	
INTERTROCHANTERIC DISTANCE IN MM			RESPIRATORY RATE	
FRAME SIZE	small medium large			
GENERAL				
SKIN	Spider angioma ___ Palmar erythema ___ Acanthosis nigricans ___Hirsutism			
HEAD	NC/AT Hair quality: Color:			
EYES	PERRLA / EOMI / Brown / Blue / Hazel / Green / Cataracts / Icterus/ Anicteric			
EARS	___TM's Intact w/ good light reflex			
NOSE	___Patent ___Symmetrical ___Discharge			
THROAT	___Clear ___Erythema Easy/Moderate/Difficult Uvular Vis.			
ORAL CAVITY	___Lesions ___Friable gums; good/fair/poor Dentition			
NECK	___Adenopathy ___Thyromegally ___Bruit ___FROM			
HEART	Reg / Irreg ____ S1 / S2 ____ M/ ___ G/ ___ R ____ Gallop			
LUNGS	___CTA Bil ___Wheezes ___Rales __Rhonchi ___Distant			
BREASTS	Male Gynecomastia: None/Mild/Moderate/ Marked	Female Exam: ___Deferred To Gyn		
ABDOMEN 	__NABS __Obese __Soft ___Stria ___Organomegaly ___Hepatomegaly ___Ascites ___Guarding ___Rebound ___CVA tendernes			
GROINS	___Rash			
UMBILICUS	___Protrusion ___lymphadnopathy			
EXTREMITIES	___Edema ___Pitting __Brawny | Depth: ____ mm			
NEUROLOGIC EXAMINATION	___Alert ___Oriented X ____ Strength R Leg___ L Leg___ R Arm___ L Arm___ ; ____DTR's			
VASCULAR EXAMINATION	Peripheral Pulses Radial: R ____ L____; DP R____ L____ PT R____ L____; Carotid R____ L____			
RECTAL EXAMINATION	____ Deferred to Endoscopy			
PELVIC EXAMINATION	____ Deferred to Gyn			

PATIENT NAME:_____ **DOB:**_____

ASSESSMENT	☐ MORBID OBESITY	☐ SLEEP APNEA
	☐ HYPERLIPIDEMIA	☐ HYPERTENSION
SWEETER %	☐ ASTHMA	☐ DIABETES
BLOATER %	☐ GASTROESOPHAGEAL RELUX DISEASE (GERD)	☐ DYSPNEA ON EXERSION
GRAZER %	☐ CLINICAL DEPRESSION	☐ DIAPHRAGMATIC HERNIA W/O OBSTR OR GNOR
	☐ OSTEOARTHRITIS	☐ FAILED GASTRIC STAPLING PROCEDURE
	☐ VENOUS STASIS DISEASE	☐ PANNICULITIS OF OTHER SITES

RECOMMENDATIONS

☐ VERTICAL BANDED GASTROPLASTY	☐ DIAPHRAGMATIC HIATAL HERNIA REPAIR W/O FUNDOPLICATION
☐ GASTRIC RESTRICTIVE PROC. OTHER THAN VBG	☐ LAPAROSCOPIC HIATAL HERNIA REPAIR WITH FUNDOPLICATION
☐ ROUX-N-Y GASTRIC BYPASS (SHORT LIMB)	☐ OPEN HIATAL HERNIA REPAIR WITH FUNDOPLICATION
☐ ROUX-N-Y GASTRIC BYPASS (ANASTAMOSIS IN THE JEJUNUM)	☐ VAGOTOMY 7 PYLORAPLASTY
☐ ROUX-N-YGASTRIC BYPASS (ANASTAMOSIS N THE ILEUM)	☐ APPENDECTOMY (POSSIBLE)
☐ REVISION OF GASTRIC RESTRICTIVE PROCEDURE	☐ CHOLECYSTECTOMY (POSSIBLE)
☐ ROUX-N-Y GASTRODUIODENOENTEROSTOMY (OR DUODENAL SWITCH)	☐ ESOPHAGOGASTRODUIODENOSCOPY (EGD)
☐ LYSIS OF ADHESIONS	☐ SLEEVE GASTRECTOMY
☐ LIVER BIOPSY	☐ ABDOMINOPLASTY

MEDICAL PERSONELL SIGNATURE: _____ **DATE:**_____

PHYSICIAN'S SIGNATURE:_____ **DATE:**_____

Advanced Bariatric Services
(ABS)
2235 Cedar Lane, Suite 101
Vienna, VA 22182
Tel (703) 778- **6000** Fax (703) 778-6005

Preoperative Checklist for Bariatric Surgery Candidates

Please read through each statement carefully and initial each that applies to you. If one or more of the questions is not a true statement, please see an office staff member so that we may rectify any issues.

1. I have received, reviewed and understand the preoperative care instructions for my procedure.
   Patient's initials:_____

2. I have received the post-operative instructions for my chosen procedure.
   Patient's initials:_____

3. I am aware that the diet history form located in my packet is to be used only as a guide and I may not turn this form in as my diet history. Instead I must submit a typewritten diet history in letter format to submit to my insurance company. I am aware that if I do not submit an acceptable diet history to the office, then submission of my information to insurance will be delayed until the diet history is received.
   Patient's initials:_____

4. I am aware that all payments for the bariatric program fee and all payments for surgical procedures must be received 14 days prior to my surgery in the form of a cashier's check or a credit card payment. A personal check will not be accepted for this payment.
   Patient's initials:_____

5. I am aware that the psychiatric evaluation that must be performed prior to my procedure must meet Dr. Elariny's approval before it can be accepted. A letter that is ambiguous or is full of skepticism from the evaluator is not considered "cleared". The patient may need counseling pre-op to correct problems that could interfere with their post-operative recovery.
   Patient's initials:_____

6. I am aware that all pre-op testing discussed with the physician's assistant or Dr. Elariny must be completed and must be done in the recommended time period prior to my weight loss procedure, otherwise my surgery will be delayed.
   Patient's initials:_____

7. I am aware that all of my pre-op test results must be faxed/mailed/e-mailed/hand-delivered to Dr. Elariny's office no later than 10 days prior to my procedure. It is my responsibility to ensure that the information is received by his office staff and made note of in time for my procedure.
   Patient's initials:_____

8. I am aware that I need to take the responsibility to schedule my pre-op testing, as well as do all follow-up as recommended by the physician who performed the test, and follow all recommendations from that doctor as appropriate.
   Patient's initials:_____

9. I am aware that if I have a sleep study and I am found to have sleep apnea, that I must obtain a CPAP machine and use it for at least 3 weeks prior to my procedure. If I arrive at the hospital the day of surgery without my C-PAP machine, my surgery may be cancelled or I may need to be in intensive care after surgery, possibly at my own extra cost.
   Patient's initials:_____

10. I am aware that after I am discharged from the hospital, I must have a ride home or to a nearby hotel from a friend or family member (not a taxi, bus, metro, etc). I may not drive myself home from the hospital under any circumstances.
   Patient's initials: _____

11. I am aware that if my home is more than 90— 100 miles away from Dr. Elariny's office in Vienna, I will need to stay in the general vicinity (within 30 miles of Fairfax Hospital or Arlington County) of Northern Virginia for a period of 8-10 days after my initial procedure is performed or 7 days after discharge from the hospital - whichever is later.
   Patient's initials:_____

12. I am aware that it is in my best interest to have a friend or family member stay with me, or for me to stay with them for the first 7-10 days after my discharge from the hospital for my own safety.
   Patient's initials:_____

13. I am aware that if I have children under the age of 10, that it is in my best interest to have alternate childcare plans in place for the first two weeks after my initial procedure, as I may not be up to my full potential to care for them.
   Patient's initials:_____

14. I am aware that after surgery, stairs and staircases are a concern, and that I must be extra cautious not to strain my incisions climbing up or down them. If I have difficulty with stairs currently, I am aware that I should avoid stairs as much as possible for the first 1-2 weeks.
   Patient's initials:_____

15. I am aware that I must have attended Dr. Elariny's discussion group at Northern Virginia Community Hospital prior to meeting with the office dietitian and Dr. Elariny, and prior to having surgery with Dr. Elariny. If I did not attend the discussion group, I will not be eligible to have surgery with Dr. Elariny.
   Patient's initials:_____

X _____

Patient's Signature

Patient's initials: _____

Today's date: _____

How To Write A Diet History

In order for your weight loss surgery request to be accepted and covered by insurance, you will need to produce a diet history, or a written explanation of your past dieting attempts. This list/history must be as comprehensive as you can possibly make it. It must include all dieting attempts in the past 5 years as applicable, and must include any and all doctor-supervised diet attempts. Some insurance companies are requesting documentation from doctors regarding your weight and other vital signs at the time of the weight loss attempts. Therefore, you must compile as much information as is available to you on your past dieting attempts in order to prepare and submit your diet history to insurance.

What you need to have:

1. The diet history must be written out in a letter format addressing the insurance company.
2. It must include all weight loss attempts that have been doctor-supervised.
3. It must include information as specific as:
    - your starting weight at the beginning of each diet attempt
    - how much weight you lost on the diet
    - how long you were actively involved in the particular weight loss attempt
    - how much/how quickly you gained the weight back
    - why the particular diet did not work for you
4. It is beneficial to have written documentation from your physicians as to why past dieting attempts were unsuccessful and/or why this option is appropriate for you.

What you need to do with this information:

1. You must generate a written letter addressing the insurance company and including all diet histories beginning with those that have been doctor-supervised and ending with "My mom put me on a diet when I was 12."
2. Each paragraph must be a separate attempt at losing weight.
3. End with your current situation, why you think diets have not worked for you and/or why you believe the option of weight loss surgery is the right one for you.

JUST DO YOUR BEST, AND BE AS COMPREHENSIVE AS POSSIBLE.

Example of a diet history: (Please do not copy this example. Note: this is not as extensive as your diet history should be.)

DATE: Today

TO: Your Insurance company

FROM: Jane Doe

SUBJECT: Diet history for weight loss surgery

Dear Sirs,

This is my history of dieting attempts. I am submitting this information in hopes of obtaining a weight loss surgery procedure to improve my health.

In *1996,* I was under the care of Dr. John Smith, and was put on the weight loss drug Fen Phen. I weighed 265 pounds at the time. I did great and lost 50 pounds in 4 months, and then it was pulled off the market. I gained 50+ pounds back in less time than it took to lose it!

In February 1997, I weighed 270 pounds when I started Optifast. I was encouraged to follow this diet on the advice of my physician, Dr. Allen Small, Alexandria, Va. I followed the diet for 8 months and lost 49 pounds total. By December of that year, I had gained back 29 of those pounds. I disliked the Optifast diet because I found it very difficult to avoid solid food and grew tired of drinking my meals.

In 1998, under the care of Dr. Small, I was sent to a dietitian at Best National hospital. I went for bi-weekly visits and lost 12 pounds in 6 weeks. I was able to maintain that weight loss for 6 months, and then the holidays came, and I put that weight back on plus another 5 pounds. By this point, my weight was around 275 pounds and I began to show signs of arthritis in my knees.

In 1999,1 began Weight Watchers with a friend. I was still under the care of Dr. Small at the time. My beginning weight was 290 pounds. I stayed on the weight watchers plan for 11 months, and in total, lost 54 pounds. At that time, I moved out of that area, and stopped the program. I slowly gained the weight back, and over the course of a year and a half, I ended up at my current weight of about 280.

In 2000, I tried dexatrim, and didn't like the side effects. I also tried going to the gym that year, but with very limited movement, it was very difficult for my almost 300 pound body, as my aching knees limited my exercise.

(This diet history is not complete. Please complete yours with an appropriate ending.)

Advanced Laparoscopic & General Surgery Associates, P.L.L.C.
2235 Cedar Lane, Suite 101,
Vienna, VA, 22182
Tel (703) 778-6000 Fax (703) 778-6005

DIET HISTORY FORM

Weight Loss Attempts in the past: Use this form as a GUIDE ONLY. You CANNOT turn this sheet in for your diet history. You will need to WRITE YOUR DIETING ATTEMPTS OUT IN A LETTER FORMAT to turn into insurance. Add any programs not listed and be as specific as possible. Your insurance company may also require letters from physicians documenting weight loss attempts, preferably that have lasted 6 months or more.

What was your approximate weight at age...

10 yrs: _____lbs 18 yrs: _____lbs 25 yrs: _____lbs 30 yrs: _____lbs 35 yrs: _____lbs 40 yrs: _____lbs

45 yrs: _____lbs 50 yrs: _____lbs 55 yrs: _____lbs 60 yrs and over: _____lbs

Name of Program	Your Description	Name of Doctor you were seeing at the time	Length of Time on Diet	Starting Weight/Total Weight Lost	Did you gain wt back? How much?	Your Comments
EXAMPLE: AminoWonder	Protein Drink	Dr. Cure I. All 120 Weightloss Ln Utopia, VA 22202	May 1991- Nov 1991	310lbs / 55 lbs	Yes, I gained 65 lbs in 4 months	I was disappointed b/c I was ten pounds heavier when it was all over!
Amphetamines (Prescribed by physicians)						
Anti-depressants to use for depression and weight loss						
Carrot juice, barley green & macrobiotic cooking						
Dexatrim / Acutrim						
Doctor Atkins						
Grapefruit diet						
Hollywood Diet						
Hypnosis						
Ionamin						
Jenny Craig						
Lighten Up						
Liquid protein / High Protein						
Low Fat						
Medical Care with dietary instruction and supervision						
Medifast						
Meridia						
Metracal						

Natural food stores: diet tea, diet pills and diet foods						
Nutrisystem						
Optifast						
Overeaters Anonymous						
Over-the-counter diet pills						
Phen Fen						
Phentermine						
Pritikin						
Redux						
Rexal Showcase, Int'l.						
Richard Simmons "Deal a Meal"						
Richard Simmons Club						
Scarsdale Diet						
Slimfast						
Spray vitamins and appetite suppressants						
Sugar Busters						
Sweet Success liquid drinks						
T.O.P.S						
The Seven-day Miracle Diet						
Vegetarian diet						
Very Low Calorie Diet						
Weight Watchers						
Xenical						

Advanced Bariatric Services
(ABS)

2235 Cedar Lane, Suite 101
Vienna, Virginia 22182
Tel (703) 778- **6000** Fax (703) 778-6005

HAZEM A. ELARJNY, MD

RELEASE FOR USE OF PHOTOGRAPHS

I,_____ , do hereby give the Staff of Advanced Laparoscopic and General Surgery Associates and Dr. Elariny absolute permission regarding any photographs taken of me pre-operatively, intraoperatively, or post-operatively in reference to my Vertical Roux-en-Y Gastric Bypass, Vertical Banded Gastroplasty, or Silicon-Adjustable Gastric Banding to use, re-use, publish, or re-publish, in whole or in part, individually or in conjunction with others, in any medium and for any purpose whatsoever, including (but not limited to)illustration, promotion, and/or advertising and trade.

I also release and discharge Advanced Laparoscopic and General Surgery Associates and Dr. Elariny from any and all claims and demands arising from or in connection with the use of my photographs, including claims for libel.

I have read and fully understand the intent and purpose of this release and am signing it without reservation.

X _____
Signatur of Patient

X _____
Date Release was Signed

X _____
Signature of Witness

Advanced Bariatric Services
(ABS)
2235 Cedar Lane, Suite 101.
Vienna, Va 22182
Tel (703) 778-6000 Fax (703) 778-6005

HAZEM A. ELARINY, MD

Consent for Weight Loss Surgery (WLS)

I,_____, hereby request that the surgeons of Advanced Laparoscopic and General Surgery Associates (ALAGSA), Dr. Hazem Elariny. and/or associates to perform upon myself:

1. Laparoscopic (Possible Open):
2. Open (Planned):
3. Revision from Conversion to:
4. Revision of:
5. Proximal Roux-en-Y Gastric Bypass (Proximal RNYGB)
6. Middle (Medial) Roux-en-Y Gastric Bypass (Middle RNYGB)
7. Vertical Banded Gastroplasty (VBG) (Silastic Ring or Mesh or other non adjustable band)
8. Vertical Gastroplasty without banding
9. Sleeve Gastrectomy
10. Adjustable Gastric Banding (Bioenterics "Lap-BAND")
11. Adjustable Gastric Banding ('Realize" Band)
12. Biliopancreatic Diversion (BPD) with Duodenal Switch (DS); (Possible Scopinaro)
13. Biliopancreatic Diversion without Duodenal Switch (Planned Scopinaro)
14. Vagotomy and Pyloric Drainage (Pyloroplasty or Pyloromyotorny)
15. Cholecystectomy
16. Appendectomy
17. Lysis of Adhesions (Possible)
18. Liver Biopsy
19. Hiatal Hernia Repair with or without fundoplication or antiret'lux wrap (Possible)
20. Esophagogastroenteroscopy (Possible)
21. Other Indicated Procedures
22. Two-stage procedure: I understand that the procedure being performed today is the first stage of a two-stage procedure. The second procedure is to be performed at a later date (usually 6 months to 18 months later) after I have accomplished a significant reduction in my body mass index (usually a 100 to 300 pound weight loss).

23. Roux Limb Length: _____or not measured/dependent.
24. Biliopancreatic Limb Length: _____or not measured/dependent.
25. Common Channel Length: _____or not measured/dependent.

_____
Patient's Initials

I understand that intraoperative findings or anatomic differences may necessitate the alteration of the procedure or the use of an alternative procedure. In some instances standard lengths, which pose a potential problem, may necessitate the use of longer or shorter lengths to allow the performance of the safest and most effective procedure as possible. If gastric partitioning is performed, this may be a physical partition only using staples and/or banding and may or may not include physical division of the two parts of the stomach (e.g. using a knife). I understand that in certain procedures stomach tissue is physically removed and in others it is not removed.

I understand that the purpose of this procedure is for the treatment of my Morbid Obesity. This is defined as being 100 lbs overweight or having a Body Mass Index (BMI) of greater than or equal to 40, or a BMI of 35-40 with at least one major comorbidity.

I have reviewed drawings of each of the available bariatric operations that diagrammatically show the main characteristics of each operation, differences among operations, advantages, and disadvantages of each procedure. I have had a chance to express to the surgeon my eating habits and behavior and my medical history, and the surgeon has helped me to personally come to a conclusion as to the most appropriate operation for me, factoring in my eating, dietary and medical background, and my future weight loss goals, pregnancy plans and personal limits regarding acceptable meal size, bowel habits, and risk tolerance. The surgeon has counseled me regarding my decision, has made professional recommendations, and we have together agreed on the planned procedure as acceptable and appropriate.

I understand that my Morbid Obesity is a disease and I attest that I have attempted and completed at least two medically supervised weight loss programs. I attest that after significant compliance with such programs, I have not been able to maintain adequate long-term weight loss.

I understand the following definitions and facts:

1. Pouch: The portion of the stomach that serves as a reservoir for food immediately after food exits the esophagus.

2. Roux Limb: The segment of small bowel that starts where food enters this segment/limb and ends where the biliopancreatic limb (bile-carrying limb) enters into the Roux limb.

3. Biliopancreatic Limb: The segment of small bowel that starts at the second portion of the duodenum where the bile duct enters the duodenum and ends when and where it enters into the Roux limb.

4. Common Channel: The segment of small bowel that starts where the biliopancreatic limb (bile-carrying limb) enters into the Roux limb and ends at the cecum. This is the segment where complex proteins and fats and carbohydrates are best digested after surgery.

5. Band: A strip of tissue or mesh or tube or a device that is wrapped around the stomach or a part of the stomach or pouch that serves to restrict the outflow of food from one part of the stomach (or from the pouch) to another part of the stomach (or to an anastamosis to the intestines).

_____

Patient's Initials

6. Anastamosis: A newly established connection between two hollow structures (such as stomach to intestines, or intestines to intestines, or intestines to colon, or bile duct to intestines). This can be a stapled connection, sewn connection, or mixed connection. Such connections can be end-to-end, end-to-side, side-to-side, or side-to-end.

7. Staple Line: A row of staples fired into bowel or stomach by a stapling device. A staple line can be within an anastamosis or in a partition or a divided bowel end. One staple line is sometimes incorporated into another, and sometimes a staple line can be incorporated into a fully hand-sewn anastamosis.

I understand the following complications and sometimes frequent and expected consequences of weight loss surgery:

1. Dumping Syndrome: A symptom complex that usually occurs with sweet or sugar intake after a procedure that excludes or obliterates the function of the pyloric sphincter. Symptoms can include some or all of the following and others: faintness, weakness, palpitations, fainting, nausea, vomiting, hypotension (low blood pressure), sweating, diarrhea of mild to explosive nature, cramps, pain and other symptoms.

2. Reflux: Acid or non-acid. Some patients will have continued acid or non-acid reflux despite surgery or will develop new reflux symptoms after surgery. This can cause burning symptoms or pain or indigestion, and can cause further complications such as Barrett's esophagus and progression to cancer, ulcerative or erosive esophagitis and progression to stricture.

3. Nausea & Vomiting: Frequently patients will experience mild to debilitating symptoms of nausea and vomiting after surgery. This can necessitate the use of one to four antiemetics that are administered orally and/or rectally as frequently as every 2 hours alternating medications and sometimes requires repeated or multiple hospitalizations. This can cause significant depression as well as other side effects and complications such as dehydration, and further consequences that can be life threatening or organ threatening (i.e. Renal failure).

4. Re-Learning to Eat: Patients will have significant changes in eating. Foods that they tolerate before surgery may become FOREVER intolerable after surgery. Patients will need to slowly re-learn what they can and cannot eat.

_____

Patient's Initials

Alternatives:

1. I attest that all alternatives currently available and in common practice in the USA have been explained to me in exhaustive detail in a discussion group setting where I have had ample opportunity to ask questions.
2. 1 have asked all questions that I wished to ask and all have been answered in a satisfactory manner and I fully understand all alternatives, risks and benefits of each operation.
3. I also attest that I have personally taken time to validate the understanding that I obtained from my surgeon and the team of Advanced Laparoscopic and General Surgery Associates, PLLC, with other sources such as the American Society of Bariatric Surgery, their internet web site, and other peer-reviewed sources, publications, and pamphlets. I understand that some of such sources may or may not have been provided by ALAGSA, and I understand that it is my responsibility to have obtained these additional information sources and that I have done so.
4. I also understand that information obtained from non peer-reviewed web sites and patient discussion groups is sometimes helpful to understand feelings, complications, habits, solutions, menus, recipes, etc. I also understand that some comments or information on such sites can he false or incorrect or misleading, and I attest that no such site has been condoned or validated by my surgeon or ALAGSA.

I certify that the staffs of Advanced Laparoscopic and General Surgery Associates and Dr. Elariny have explained the details of the procedural options and the procedure that I have chosen to have with the counseling of my surgeon. Explanation has been in full and ALAGSA and my surgeon have informed me of the medical and surgical alternatives, operative risks, possible complications, expected outcome, and long-term changes which may or may not occur. I understand that if I have requested a laparoscopic procedure, that the surgeons of ALAGSA will do everything possible to perform the procedure laparoscopically as long as doing so does not compromise my medical safety or the quality of the bariatric or general surgical procedure being performed. I understand that it may be necessary to convert the procedure to an open technique if it is felt to be the best medical / surgical decision in the judgment of my surgeon (s). TI understand that my current weight poses significant risks for shortening my life and/or causing or worsening the severity of various disease states such as hypertension (high blood pressure), diabetes, arthritis in my lower extremities and back, gallbladder trouble, shortness of breath and fatigue, stress urinary incontinence (leaking urine with straining), sleep apnea and others. I have been counseled about other surgical and non-surgical options and techniques available for treating obesity, including but not limited to those listed in the procedure list above in this consent, gastric balloon (available only outside the USA), various diets and weight-reducing plans with or without the use of medications, exercise regimens, psychological or psychiatric therapy, and other regimens, and I have made numerous attempts at permanent weight loss in the past, all without long-lasting success. I understand that there is no plan to reverse this operation in the future and it is therefore considered to be permanent. I also understand that this surgical procedure is not without risks of a technical nature and these specifically include, but are not limited to the possibility of 1) a leak of fluid from the esophagus and/or stomach and/or small intestine, or any anastamosis or staple line; 2) narrowing of any anastamosis causing an obstruction which may require dilatation or even repeat surgery; 3) bleeding into the upper gastrointestinal tract, or into the abdominal cavity; 4) failure of the staple lines or dilation of the pouch or remaining stomach, allowing me to regain my lost weight at any time in the future (sometimes because the patient is not following directions concerning what and how much to eat or drink after the operation); *5)* infection in my incision; 6) infection inside the abdominal cavity which might require re-operation; 7) blood clots in my legs

_____

Patient's Initials

which could break loose and travel to my lungs (especially if I am less active after the surgery than I have been instructed to be); 8) a hernia through the incision; and 9)injury to other internal organs, 10) failure intra-operatively or at anytime post-operatively of the equipment used to perform the surgery including but not limited to stapling devices, suturing devices, mechanical, electrical, and other cutting devices that could lead to immediate changes in the procedure to correct such failure or later re-operation or other intervention to correct such failure or consequence of such failure. Finally, I am aware that it is even possible that under the very worst of circumstances, these complications could result in my death despite the optimal efforts of all the health professionals involved in my care. It has been explained to me in detail that this operation may indeed not cause me to lose weight, or not to lose as much as expected, and that my surgical options may be very limited in that circumstance. I have been counseled on the expected excess body weight loss from the procedure I have requested, and I understand that my weight loss may be much more or less than what is expected.

I have been counseled regarding the options of varied roux limb length and common channel length to affect malabsorption and potentially improve the expected long-term weight loss. I understand that this is not guaranteed, and I understand that as the length of the roux limb increases (for gastric bypass), or as the length of the biliary limb increases (for BPD), or as the length of the common channel decreases (for any WLS procedure), so too the risk of complications and malabsorption increase. I understand that the gastric reservoir (pouch) size varies among procedures. After ample thought and discussion I have decided on the procedure and specifics above. I also understand that varying roux limb centimeter length based on pre-op weight and patient personal goals is not a scientifically proven method, but is a common practice. I attest that I have not been told that specific results can be expected from differing limb lengths, but rather that generalizations can be made based on varied limb lengths. For example a shorter common channel will in general increase the risk of malnutrition, vitamin deficiency and diarrhea and may increase the excess body weight loss.

I realize that the surgeons of Advanced Laparoscopic and General Surgery Associates may feel the need to call in other physicians (anesthesiologists, internists, surgeons, etc.) or health care professionals to assist in my care if, in their opinion, the situation so dictates and I agree to this as well. Other side effects *I* complications of weight loss surgery which may occur include temporary partial hair loss, the inability to tolerate certain foods (which is in many regards unpredictable), a period of fatigue compared to my pre-operative strength and stamina, which may never return to normal, and an increased chance of becoming pregnant (if I am female, sexually active, and still have that capability), because of resumed hormonal function, improvement in polycystic ovarian condition, decreased oral contraceptive effectiveness, or other social changes. I have been counseled to take all necessary steps and measures needed to prevent pregnancy for at least one full year after surgery and understand this may occur by 1) abstinence, 2) tubal ligation, *3)* vasectomy of male sexual partner 4) Intrauterine device, *5)* hormone Implant, 6) monthly hormone injection. I understand that shield methods alone are not adequately effective to accomplish this, and oral contraceptives are not reliable for contraception after WLS and I will seek the medical guidance I need from my primary physician or gynecologist to arrange for adequate contraception preoperatively and perform it post-operatively. If I become pregnant at any time after surgery, I understand that newborns of BPD patients are usually healthy at birth, but are commonly below average in weight, and over one in five women with BPD type procedures will require parenteral nutritional support during pregnancy and this may be associated with complications.

_____

Patient's Initials

I have also been informed about the possibility of the "dumping syndrome" from eating sweets after some WLS procedures, especially gastric bypass, and of the future risks of ulcer disease, anemia, or deficiencies of iron, calcium, folic acid, vitamin B12, Vitamin A, D, E, K, and other vitamins or trace elements. It has been explained to me that some patients will have better success if they undergo psychiatric or psychological counseling before, during, and/or after the weight loss period and I agree to seek such assistance if recommended by Advanced Laparoscopic and General Surgery Associates or Dr. Elariny in the future. For my part, I agree to follow the directions as spelled out in the information given to me prior to surgery including beginning to exercise more regularly and more vigorously (as my physical condition allows); to take the recommended medications and supplements as detailed on the pre-operative and post-operative instructions I have been given; to be faithful in keeping my follow-up appointments in the office so that my progress can be monitored more accurately; to get appropriate laboratory work as needed in the future; and to do my best to attend Support Group sessions on a regular basis since it has been shown that patients generally do better if they attend these meetings. And if I smoke, to do my best to quit smoking tobacco six weeks before surgery and at least for 6 weeks after surgery and do my best to never resume smoking. I will also abstain from alcohol consumption for at least three weeks before and three months after surgery. I understand that alcohol consumption may increase the risk of complications such as ulcers, gastritis, pancreatitis, hepatitis, nausea and vomiting. I understand that the surgeons of Advanced Laparoscopic and General Surgery Associates or Dr. Elariny will be available to help me with surgical problems that may arise or that they will have arranged for a competent physician to be available for coverage during their absence from the community. I understand that this availability will be in force only as long as Dr. Elariny continues to practice bariatric surgery in Northern Virginia and that such availability is limited geographically to the hospital(s) where Dr. Elariny or the on-call physician maintain privileges. I realize that I am at higher than average risk to undergo major abdominal surgery because of my weight and associated medical problems (many of which this operation and the resulting weight loss are intended to correct) and consent to the procedure with this knowledge in mind. I may have special medical problems of which I am fully aware, and I understand that these may also influence the ease and difficulty of the procedure as well as the attendant risks and potential complications. I understand that every effort will be made by the entire team of health care professionals involved in my case to assure that I have the best result possible given my original condition, but further recognize that some problems are unavoidable even with the best of intentions and the optimal care I expect. **This request form is being signed with full understanding of the above information and with my signature, I certify that I am making this request after reading this entire form and all references made by this form and after due consideration of these facts and after having had all my questions answered to my complete satisfaction.**

X _____ X _____

Signature of Patient Date Signed

X _____

Witness to Patients Signature

X _____ X _____

Signature of Surgeon Date Signed

BOLD Preoperative Encounter Form

Last Name _____ First Name _____ Chart Number _____

Date of Visit _____ Height _____ ☐ in ☐ cm Weight _____ ☐ lbs ☐ kgs

CO-MORBIDITIES (you must select ONLY ONE per category for each system)

CARDIOVASCULAR DISEASE

Hypertension
- ☐ No history
- ☐ Borderline, no medication
- ☐ Diagnosis of hypertension, no medication
- ☐ Treatment with single medication
- ☐ Treatment with multiple medications
- ☐ Poorly controlled by medications, organ damage

Congestive Heart Failure
- ☐ No history or symptoms of congestive heart failure
- ☐ Class I: Symptoms with more than ordinary activity
- ☐ Class II: Symptoms with ordinary activity
- ☐ Class III: Symptoms with minimal activity
- ☐ Class IV: Symptoms at rest

Ischemic Heart Disease
- ☐ No history of ischemic heart disease
- ☐ Abnormal ECG, no active ischemia
- ☐ History of MI or anti-ischemic medication
- ☐ PCI, CABG
- ☐ Active ischemia

Angina Assessment
- ☐ No chest pain symptoms/angina
- ☐ Anginal chest with extreme exertion (e.g. running, swimming, etc.)
- ☐ Anginal chest pain occurs with moderate activity or exertion
- ☐ Anginal chest pain with minimal exertion (e.g. walking across a room) or at rest
- ☐ Unstable angina

Peripheral Vascular Disease
- ☐ No symptoms of peripheral vascular disease
- ☐ Asymptomatic with bruit
- ☐ Claudication, anti-ischemic medication
- ☐ Transient ischemic attack, rest pain
- ☐ Procedure for peripheral vascular disease
- ☐ Stroke, loss of tissue secondary to ischemia

Lower Extremity Edema
- ☐ No symptoms of lower extremity edema
- ☐ Intermittent lower extremity edema, not requiring treatment
- ☐ Symptoms requiring treatment, diuretics, elevation, or hose
- ☐ Stasis ulcers
- ☐ Disability, decreased function, hospitalization

DVT/PE
- ☐ No history of DVT/PE
- ☐ History of DVT resolved with anticoagulation
- ☐ Recurrent DVT long term anticoagulation meds
- ☐ Previous PE
- ☐ Recurrent PE, decreased function, hospitalization
- ☐ Vena Cava filter

METABOLIC

Glucose Metabolism
- ☐ No symptoms or evidence of diabetes
- ☐ Elevated fasting glucose
- ☐ Diabetes, controlled with oral medication
- ☐ Diabetes, controlled with insulin
- ☐ Diabetes, controlled with insulin and oral medication
- ☐ Diabetes, with severe complications (retinopathy, neuropathy, renal failure, blindness)

Lipids (Dyslipidemia or Hyperlipidemia)
- ☐ Not present
- ☐ Present, no treatment required
- ☐ Controlled with lifestyle change, including Step 1 or Step 2 diet
- ☐ Controlled with single medication
- ☐ Controlled with multiple medications
- ☐ Not controlled

Gout Hyperuricemia
- ☐ No symptoms of gout/hyperuricemia
- ☐ Hyperuricemia, no symptoms
- ☐ Hyperuricemia, medications
- ☐ Arthropathy
- ☐ Destructive joints
- ☐ Disability, unable to walk

PULMONARY

Obstructive Sleep Apnea Syndrome
- ☐ No symptoms or evidence of obstructive sleep apnea syndrome
- ☐ Sleep apnea symptoms (negative sleep study or not done)
- ☐ Sleep apnea diagnosis by sleep study (no oral appliance)
- ☐ Sleep apnea requiring oral appliance such as CPAP
- ☐ Sleep apnea with significant hypoxia or oxygen dependent
- ☐ Sleep apnea with complications (pulmonary HTN, etc.)

Obesity Hypoventilation Syndrome
- ☐ No symptoms of obesity hypoventilation
- ☐ Hypoxemia/hypercarbia on room air
- ☐ Severe hypoxemia or hypercarbia
- ☐ Pulmonary hypertension
- ☐ Right heart failure
- ☐ Right heart failure - left ventricular dysfunction

Pulmonary Hypertension
- ☐ No symptoms or indication of pulmonary hypertension
- ☐ Symptoms associated with PH(tiredness, SOB, dizziness, fainting)
- ☐ Confirmed PH diagnosis
- ☐ Well controlled on anticoagulants and/or calcium channel blockers
- ☐ Stronger medications and/or oxygen
- ☐ Patient needs or has had lung transplant

Asthma
- ☐ No symptoms of asthma
- ☐ Intermittent mild symptoms, no medication
- ☐ Symptoms controlled with oral inhaler (such as albuterol)
- ☐ Well controlled with ongoing daily medication
- ☐ Symptoms not well controlled, steroids or anticholinergics
- ☐ Hospitalized within last 2 years, history of intubation

GASTROINTESTINAL

GERD
- ☐ No history of GERD
- ☐ Intermittent or variable symptoms, no medication
- ☐ Intermittent medication
- ☐ H2 blockers or low dose PPI
- ☐ High dose PPI
- ☐ Meet criteria for antireflux surgery, or prior surgery for GERD

Cholelithiasis
- ☐ No history of gallstones
- ☐ Gallstones with no symptoms
- ☐ Gallstones with intermittent symptoms
- ☐ Gallstones with severe symptoms or h/o cholecystectomy
- ☐ Gallstones with complications requiring immediate surgery prior to gastric bypass
- ☐ History of cholecystectomy with ongoing complications not resolved

Liver Disease
- ☐ No history of liver disease
- ☐ Hepatomegaly modest, normal LFT's, fatty change Category 1
- ☐ Modest or greater hepatomegaly, LFT alteration, fatty change Category 2
- ☐ Moderate to marked hepatomegaly, fatty change Category 3, mild inflammation, mild fibrosis
- ☐ Definite NASH, cirrhosis, hepatic dysfunction by LFT's
- ☐ Hepatic failure, transplant indicated or done

CO-MORBIDITIES (continued) (You must select ONLY ONE per category for each system)

MUSCULOSKELETAL

Back Pain
- ☐ No symptoms of back pain
- ☐ Intermittent symptoms not requiring medical treatment
- ☐ Symptoms requiring non-narcotic treatment
- ☐ Degenerative changes or positive objective findings, symptoms requiring narcotic treatment
- ☐ Surgical intervention done or recommended pending weight loss
- ☐ Failed previous surgical intervention with existing symptoms

Musculoskeletal Disease
- ☐ No symptoms of musculoskeletal disease
- ☐ Pain with community ambulation
- ☐ Non narcotic analgesia required
- ☐ Pain with household ambulation
- ☐ Surgical intervention required (ex: arthroscopy)
- ☐ Awaiting or past joint replacement or other disability

Fibromyalgia
- ☐ No history of fibromyalgia
- ☐ Treatment with exercise
- ☐ Treatment with non-narcotic medications
- ☐ Treatment with narcotics
- ☐ Treatment with narcotics: Surgical intervention done or recommended
- ☐ Disabling, treatment not effective

REPRODUCTIVE

Polycystic Ovarian Syndrome
- ☐ No history of polycystic ovarian syndrome
- ☐ Symptoms of PCOS, no treatment
- ☐ OCP's or anti-androgen Rx
- ☐ Medformin or TZD
- ☐ Combination therapy
- ☐ Infertility

Menstrual Irregularities (not PCOS)
- ☐ No history of menstrual irregularities
- ☐ Irregular periods or oligomenorrhea
- ☐ Menorrhagia
- ☐ Amenorrhea
- ☐ Prior total abdominal hysterectomy

PSYCHOSOCIAL

Psychosocial Impairment
- ☐ No impairment
- ☐ Mild impairment in psychosocial functioning but able to perform all primary tasks
- ☐ Moderate impairment in psychosocial functioning but able to perform most primary tasks
- ☐ Moderate impairment in psychosocial functioning and unable to perform some primary tasks
- ☐ Severe impairment in psychosocial functioning and unable to perform most primary tasks
- ☐ Severe impairment in psychosocial functioning and unable to function

Depression
- ☐ No symptoms of depression
- ☐ Mild and episodic not requiring treatment
- ☐ Moderate, accompanied by some impairment, may require treatment
- ☐ Moderate with significant impairment, treatment indicated
- ☐ Severe, definitely requiring intensive treatment
- ☐ Severe requiring hospitalization

Confirmed Mental Health Diagnosis
- ☐ None
- ☐ Bipolar disorder
- ☐ Anxiety/panic disorder
- ☐ Personality disorder
- ☐ Psychosis

Alcohol Use
☐ None ☐ Rare ☐ Occasional ☐ Frequent

Tobacco Use
☐ None ☐ Rare ☐ Occasional ☐ Frequent

Substance Abuse (Prescription or Illegal)
☐ None ☐ Rare ☐ Occasional ☐ Frequent

GENERAL

Stress Urinary Incontinence
- ☐ No history of stress urinary incontinence
- ☐ Minimal and intermittent
- ☐ Frequent but not severe
- ☐ Daily occurrence, requires sanitary pad
- ☐ Disabling
- ☐ Operation ineffective

Functional Status
- ☐ No impairment of functional status
- ☐ Able to walk 200ft with assistance device (cane or crutch)
- ☐ Cannot walk 200ft with assistance device (cane or crutch)
- ☐ Requires wheelchair
- ☐ Bedridden

Pseudotumor Cerebri
- ☐ No symptoms of pseudotumor cerebri
- ☐ Headaches with dizziness, nausea, and/or pain behind the eyes, no visual symptoms
- ☐ Headaches with visual symptoms and/or controlled with diuretics
- ☐ Patient has had MRI to confirm PTC, is well controlled with oral diuretics
- ☐ Patient is well controlled with stronger medications
- ☐ Patient requires narcotics or has had (or needs) surgical intervention

Abdominal Skin/Pannus
- ☐ No symptoms
- ☐ Intertriginous irritation
- ☐ Pannus so large it interferes with ambulation
- ☐ Recurrent cellulitis, ulceration
- ☐ Surgical treatment required

Abdominal Hernia
- ☐ No hernia
- ☐ Asymptomatic hernia, no prior operation
- ☐ Symptomatic hernia with or without incarceration
- ☐ Successful repair
- ☐ Recurrent hernia or size > 15 cm
- ☐ Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs

MEDICATIONS/VITAMINS & MINERALS

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Multiple Vitamin ☐ Calcium ☐ Vitamin B-12 ☐ Iron ☐ Vitamin D ☐ Vitamin A, D, E Combo ☐ Calcium with Vitamin D

SIGNATURE (Name and Signature of person completing Encounter Form)

Name (print) _____ Signature _____

Advanced Laparoscopic and General Surgery Associates, PLLC
2235 Cedar Lane, #101, Vienna, VA 22182
Tel (703) 778-6000 Fax (703) 778-6005

Patient Name: DOB:

MEDICATIONS	DAILY DOSAGE

****PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING.**

CANCELLATION POLICY:

IF YOU INTEND TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE GIVE US A CALL AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TIME. IF YOU FAIL TO INFORM OUR OFFICE, YOU WILL BE CHARGED $100.00

THANK YOU,

MANAGEMENT

AS OF September 1st, 2012