New Patient Packet

Please complete the included forms prior to your first appointment.

●

If you do not complete the forms prior to your appointment, you may experience significant delays, or you may be asked to reschedule.

●

Please arrive 30 minutes 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

Thank you for considering Dr. Elariny or one of the Pinnacle Surgical Group associates as your potential bariatric surgeon. Our goal is to provide you with the most informative, valuable, and comfortable experience available. If you choose to proceed, we will guide you through the required steps to successfully obtain a surgery, but we will need your cooperation and assistance to make the process as smooth as possible.

When you come for your first visit, please bring the following items:

1) Copy of insurance card, valid photo ID, and co-pay (Check, cash, credit accepted)
2) List of all medications (including over-the-counter and herbal), past medical and surgical history
3) Documentation of prior supervised weight loss attempts (e.g. doctor's office visit notes, and/or records from diet programs [Weight Watcher's, Medifast, etc.], dietitian, or personal trainer)
4) Documentation from your primary care doctor regarding treatment for weight-related conditions or comorbidities
5) Operative reports, recent endoscopy, or upper GI studies if you have had previous weight loss surgery or other major surgery

You can use the following spaces to document your appointment times. We ask that you attend the bariatric discussion group or webinar prior to your first appointment so that you can familiarize yourself with our approach to weight loss surgery.

Bariatric Discussion Group
Various Days, 5:00-8:00 PM
2235 Cedar Lane, Suite 101
Vienna, VA 22182

OR

Appt: _____
Various days/times, INOVA Fair Oaks
Seminar Conference Room
3700 Joseph Siewick Dr.
Fairfax, VA 22033

First Appointment
(With MD, dietitian, & insurance coordinator)
2235 Cedar Lane, Suite 101
Vienna, VA 22182

Appt: _____

Bariatric program fee will be collected when your insurance company approves your procedure. This covers expenses related to your care in the first post-operative year.

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*DIRECTIONS to the OFFICE from the **WEST***

Interstate 66	Take I66 EAST towards Washington, DC
	Take exit 64B for I495 NORTH twd Tysons Corner/Baltimore
	Take exit 47A for Leesburg Pike (Rte 7) WEST twd Tysons Corner
	Make a LEFT onto Gallows Road
	FOLLOW Gallows Road a little over 1 mile south
	Make a RIGHT between the Sunoco gas stations onto Cedar Lane
	The office is ¼ mile down Cedar Lane on the left

*DIRECTIONS to the OFFICE from the **NORTH***

Beltway 495	Heading SOUTH on 495
	Take the Leesburg Pike (Rte 7) exit 47A WEST twd Tysons Corner
	Make a LEFT onto Gallows Road
	FOLLOW Gallows Road a little over 1 mile south
	Make a RIGHT between the Sunoco gas stations onto Cedar Lane
	The office is ¼ mile down Cedar Lane on the left

*DIRECTIONS to the OFFICE from the **SOUTH***

I95 North	Take I95 NORTH to 495 WEST twd Tysons Corner
	Take the Gallows Road (VA-650) exit (51)
	Turn LEFT onto Gallows Road
	Follow Gallows Road for 3.5 miles
	Make a LEFT between the Sunoco gas stations onto Cedar Lane
	The office is ¼ mile down Cedar Lane on the left
Southern MD	Take I95/I495 SOUTH twd Richmond
	Follow the beltway twd Tysons Corner
	Take the Gallows Road (VA-650) exit (51)
	Turn LEFT onto Gallows Road
	Follow Gallows Road for 3.5 miles
	Make a LEFT between the Sunoco gas stations onto Cedar Lane
	The office is ¼ mile down Cedar Lane on the left

*DIRECTIONS to the OFFICE from **WASHINGTON, DC***

I66 West	Take I66 WEST to exit 66B for Leesburg Pike twd Tysons Corner
	Turn LEFT onto VA-695/Idylwood Rd
	FOLLOW Idylwood Rd for over 1.5 miles
	Turn RIGHT onto Gallows Road, and FOLLOW for about 0.5 miles
	Make a LEFT between the Sunoco gas stations onto Cedar Lane
	The office is ¼ mile down Cedar Lane on the left

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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 CARE. RECORDS MAY BE SENT TO REFERRING PHYSICIANS, SPECIALISTS, HOSPITALS, PRE-OP CENTERS, INSURANCE OR FINANCING AGENCIES OR OTHER ENTITIES, PERSONS, OR PROFESSIONALS 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 Pinnacle Surgical Group (PSG) and its employees are acting in good faith and I certify that I will indemnify and hold PSG and its employees harmless for any such delivery error or its consequences.

<table>
<tr><td colspan="3">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 10¢/page)
USPS: ($0.40 + 10¢/page)
FedEx: ($0.40 + 10¢/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 #</td></tr>
<tr><td>Phone#</td><td>Email Address:</td></tr>
</table>

I agree to receive email/faxes regarding my medical condition from my doctor or PSG. 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. Furthermore, I understand that any correspondence sent via email does not ensure the strictest confidentiality standards.

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

OR

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

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

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) _____(MI)_____(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:_____
Social Security #: _____
Address: (Street)_____(APT#)_____
(City)_____(State)_____(Zip)_____
Phone#: (____)_____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 Agreemet 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 BARIATRIC SERVICES ("PSG") AND ITS PHYSICIANS AND EMPLOYEES TO PROVIDE PROFESSIONAL MEDICAL SERVICES TO THE 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 PSG WHO ENGAGES IN MY CARE.

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

IN THE EVENT THAT A PSG 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 PSG 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 PSG PROVIDER CONTRACTS WITH BUT I AM UNDERGOING A NON-COVERED OR NON-CONTRACTED SERVICE OR A SERVICE FOR WHICH A DENIAL OF BENEFITS HAS BEEN ISSUED BY MY MCO, I AM RESPONSIBLE FOR PAYMENT IN 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 CLAIM THAT ARISES IN SUCH CIRCUMSTANCE AGAINST PROVIDER.

IN THE EVENT I HAVE SUPPLIED INACURATE 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 IN 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 PSG 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 PSG AND PROVIDERS TO INCLUDE DATA DERIVED 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 PSG OR THE PROVIDER.

IF I AM A MEDICARE PATIENT, I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE TO PSG AND/OR PROVIDER FOR ANY SERVICES FURNISHED TO ME BY PSG 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 RENDERED BY PSG AND ASSOCIATES AND IS NON-REVOKABLE EXCEPT THROUGH MY REFUSAL TO ACCEPT FUTURE SERVICES. ANY ACCEPTANCE OF SERVICES UPON MYSELF OR PATIENT BY PSG IS IPSO FACTO AND BY DEFAULT A REAFFIRMATION OF THIS AUTHORIZATION STATEMENT.

X _____

Signature of Patient OR Authorized Agent

X _____

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:		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 o Chronic obstructive pulmonary disease (COPD)	
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 Myocardial infarction (MI) o Pulmonary Embolism o Hypertension o Deep Vein Thrombosis (DVT)	
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 Gastroesophageal reflux disease (GERD) o Gastritis o Diverticulitis o Liver cirrhosis o Crohn's disease o Ulcerative Colitis o Irritable Bowel Syndrome	
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 Stroke o Transient ischemic attack (TIA)	
PSYCH	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 o Hypercoagulable state	
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	
Do you have any history of methicillin-resistant staphylococcus aureus (MRSA)?	Yes No	
Have you ever had total parenteral nutrition (TPN) or nutrition by IV?	Yes No	
Have you ever been hospitalized for reasons other than surgery? *If so list why, and which hospital*	Yes No	
What **medicines** do you take regularly? *Please provide the dose and how often*		
Do you or have you ever taken the following medications?	Yes No	Steroids / Estrogens / Amiodarone / Perhexiline / Nifedipine / NSAIDs
What **allergies** do you have? Medication / Food / Latex / Other		

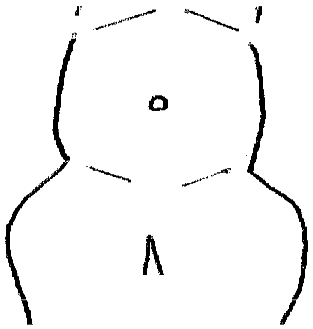
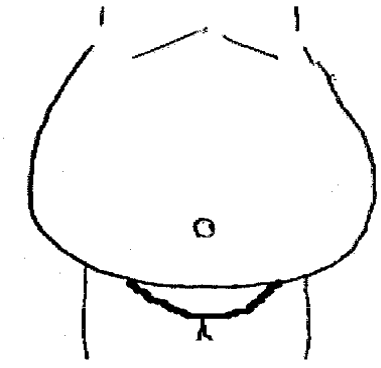
What surgeries, injuries, operations, and/or fractures have you had in your life? *Circle those that apply and add those not listed*		Tonsillectomy / Appendectomy / Gallbladder / Hysterectomy (complete / partial) / Stomach Surgery
What diseases have your relatives had?		Example: Breast Cancer, Colon Cancer, Heart Attack, Stroke, Obesity, Diabetes, Hypertension, etc.
Father:		
Mother:		
Brother:		
Sister:		
Children:		
How many children do you have? *Provide date of birth*	N/A	
Do you currently smoke tobacco? When did you start?	Yes No	
If you quit, when did you quit? For how many years did you smoke?	N/A	
How many packs of cigarettes per day do/did you smoke?	N/A	
If you still smoke, do you promise to quit today?	Yes No	
Do/did you chew tobacco?	Yes No	
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?	N/A	
Have you ever had your Colon checked? *How? When?*	Yes No	Date: Results:
When was your last chest X-ray?	N/A	Date: Results:
When was your last EKG?	N/A	Date: Results:
MEN: When was your last PSA (Prostate Specific Antigen) checked?	N/A	Date: Results:

MEN: When was your last prostate exam?	N/A	Date:	Results:
MEN: Do you know about self-testicular examination?	Yes No		
WOMEN: When did you have our first menstrual period?	N/A	Age:	
WOMEN: Are you menopausal?	Yes No		
WOMEN: When was your last, most recent menstrual period?	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?	N/A	Date:	Results:
WOMEN: When was your last mammogram?	N/A	Date:	Results:
WOMEN: Do you know about self-breast examination?	Yes No		
What blood tests have you had in the past 6 months, and what were the results?	N/A		
What X-rays or imaging studies have you had in the past 6 months, and what were the results?	N/A		
Do you have any specific questions you expect answered today?	Yes No		

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)

Patient's Name: _____ DOB:_____

PHYSICAL EXAMINATION	**DATE OF PHYSICAL _____/_____/_____**			
HEIGHT			TEMPERATURE	
WEIGHT			PULSE	
BMI		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 ___ Lesions			
HEAD	___ NC/AT Hair quality: Color:			
EYES	___ PERRLA ___ EOMI ___ Anicteric Color:			
EARS	___ TMs intact ___ Hearing Difficulty			
NOSE	___ Patent ___ Symmetrical ___ Discharge ___ Septal defect			
THROAT	___Clear ___Erythema Easy / Moderate / Difficult Uvular Vis.			
ORAL CAVITY	___ Lesions ___ Friable gums Good / Fair / Poor Dentition			
NECK	___ Supple ___ Adenopathy ___ Thyromegaly ___ Bruit ___ FROM			
HEART	Reg / Irreg ___ S1 / S2 ___ M/___G/ ___R ___ Gallop			
LUNGS	___CTAB ___Wheezes ___ Rales ___ Rhonchi ___ Distant ___Nl Effort			
BREASTS	Male Gynecomastia: None / Mild / Moderate / Marked	Female Exam: ___Deferred to GYN		
ABDOMEN 	___ NABS __Obese __Soft ___Stria ___ Ascites ___Splenomegaly ___Hepatomegaly ___Rebound ___ Guarding ___CVA tenderness ___ Masses ___ Bruit			
GROINS	___ Rash ___ Hernia (R / L)			
UMBILICUS	___ Hernia ___ Lymphadenopathy			
EXTREMITIES	___ Edema ___Pitting (Depth: ____ mm) ___ Brawny ___ Varicosities			
NEUROLOGIC EXAMINATION	___Alert ___Oriented x ____ || ___ Non-focal ___ Nl Gait Strength: R Leg ___ L Leg ___ R Arm ___ L Arm ___ || ___ DTRs			
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
	☐ OSTEOARTHRITIS	☐ FAILED GASTRIC STAPLING PROCEDURE
	☐ VENOUS STASIS DISEASE	☐ PANNICULITIS OF OTHER SITES

RECOMMENDATIONS

☐ Open ☐ Laparoscopic ☐ Robotic

☐ LAP BAND	☐ APPENDECTOMY ☐ (Possible)
☐ SLEEVE GASTRECTOMY (___ Bougie) ☐ With 40 Bougie Short Segment ☐ With Lap Band	☐ CHOLECYSTECTOMY ☐ (Possible)
☐ VERTICAL BANDED GASTROPLASTY	☐ HIATAL HERNIA REPAIR ☐ (Possible) ☐ With ☐ Without Fundoplication/"Fat wrap"
☐ PROXIMAL ROUX-EN-Y GASTRIC BYPASS	☐ VAGOTOMY / PYLOROPLASTY
☐ BILIOPANCREATIC DIVERSION-DUODENAL SWITCH (BPD-DS)	☐ REVISION OF GASTRIC RESTRICTIVE PROCEDURE ☐ BPD (a.k.a. JEJUNOJEJUNOSTOMY) ☐ POUCH IMBRICATION or REVISION
☐ LIVER BIOPSY	
☐ LYSIS OF ADHESIONS ☐ (Possible)	
☐ ESOPHAGOGASTRODUODENOSCOPY (EGD)	☐ HERNIA REPAIR (Location:)
☐ COLONOSCOPY	☐ ABDOMINOPLASTY
☐	☐
☐	☐

MEDICAL PERSONEL SIGNATURE: _____ **DATE:**_____

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

Advanced Bariatric Services
2235 Cedar Lane, Suite 101 • Vienna, VA 22182
Tel (703)778-6000 • Fax (703)778-6005
Hazem A. Elariny, MD

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 that I am personally responsible for 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. Final suitability to proceed with surgery will be determined by Dr. Elariny.
   Patient's initials: _____

6) I am aware that all pre-operative testing discussed with Dr. Elariny and/or the staff of Advanced Bariatric Services must be completed in the recommended time period prior to my weight loss procedure. Failure to adhere to the recommended testing or testing schedule may result in delay or cancellation of my procedure.
   Patient's initials: _____

7) I am aware that all of my pre-operative 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 filed appropriately in time for my procedure.
   Patient's initials: _____

8) I am aware that I am responsible for scheduling my pre-operative testing in a timely fashion. Furthermore, I am responsible for all follow-up as recommended by the physician who performed the test, and I will 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 on the day of my surgery without

my CPAP machine, I understand that my surgery may be cancelled or that I may need to be monitored in the intensive care unit after surgery, possibly at my own extra cost. Furthermore, I understand that not using a CPAP machine if it has been recommended to me increases my risk of peri-operative pulmonary complications.
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 and understand that by doing so I am putting myself and others at unnecessary risk.
Patient's initials: _____

11) I am aware that if my home is more than 90 miles away from Dr. Elariny's office in Vienna, VA, I will need to stay in the general vicinity (within 30 miles of the hospital where surgical care is provided) for a period of 8-10 days after my procedure is performed or 7 days after discharge from the hospital – whichever is later. I will attend my 1 week follow-up in the office.
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 my surgery, stairs and staircases will be concerns 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. Furthermore, I am aware that no heavy lifting more than 10-15 pounds is to be performed for 6 weeks after my surgery to minimize the risk of hernia formation
Patient's initials: _____

15) I am aware that I must have attended Dr. Elariny's discussion group 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 may not be eligible to have surgery with Dr. Elariny.
Patient's initials: _____

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 ("pre-authorized"), you will need to produce a diet history, or a written explanation of your past dieting attempts. In order to maximize success, this list/history must be as comprehensive as you can possibly make it. The diet history must include *all* of your dieting attempts in the past 5 years, and *must* include any and all physician-supervised diet attempts. Some insurance companies may also request documentation from doctors regarding your weight and other vital signs at the time of your 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 the most effective diet history to your insurance company. As with all steps of this process, doing your best to provide high quality assistance can only help you proceed promptly and efficiently toward surgery.

To produce the best diet history, you will need to have the following:

1) It must include all weight loss attempts that have been physician-supervised.
2) It must include information as specific as:
    a. Your starting weight at the beginning of each diet attempt
    b. How much weight you lost on the diet
    c. How long you were actively involved in the particular weight loss attempt
    d. How much/how quickly you gained the weight back
    e. Why the particular diet did not work for you
3) It is beneficial to have written documentation from your physician as to why past dieting attempts were unsuccessful and/or why surgery is appropriate for you

What you need to do with this information:

1) You must generate a formal written letter specifically addressing your insurance company, which includes all diet histories. Begin with those that have been physician-supervised, followed by any commercial weight programs (Weight Watchers, Jenny Craig, Medifast, etc.), and ending with any personally attempted diets (e.g. "my mom first placed me on a diet when I was 12 years old").
2) Each paragraph must be a separate attempt at losing weight.
3) End the letter with your current situation, why you believe that diets have not worked for you, and why you believe that weight loss surgery is the appropriate solution

JUST DO YOUR BEST. REMEMBER TO BE AS COMPREHENSIVE AND THOROUGH AS POSSIBLE AND YOU WILL BE FINE.

An example of a diet history is provided in this packet. Please do not copy this example exactly as written. It has been provided as a template to follow, but is not as extensive as your actual diet history letter should be.

DATE: Today

TO: Your Insurance company

FROM: Jane Doe

SUBJECT: Diet history for weight loss surgery

To Whom It May Concern,

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, I 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. I now also have been told that I have "pre-diabetes" and high blood pressure.

I believe that weight loss surgery is an appropriate option because I have several acquaintances and family members who have maintained their weight loss after their surgeries and we have very similar backgrounds and weight loss attempts.

(*Remember, this diet history is NOT as detailed as yours should be and serves as an example of how to approach this letter*)

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 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
2235 Cedar Lane, Suite 101 • Vienna, VA 22182
Tel (703)778-6000 • Fax (703)778-6005
Hazem A. Elariny, MD

RELEASE FOR USE OF PHOTOGRAPHS

I, _____, do hereby give the staff of Advanced Bariatric Services and Dr. Elariny absolute permission regarding any photographs taken of me pre-operatively, intra-operatively, or post-operatively in reference to any procedure performed by Dr. Elariny and/or his associates to use, reuse, publish, or republish, 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 Bariatric Services 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 _____

Signature of Patient

X _____

Date Release was Signed

X _____

Signature of Witness

Advanced Bariatric Services
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 Bariatric Services, Dr. Hazem A. Elariny, and/or associates to perform upon myself:

- ❑ Laparoscopic (Possible Open):
- ❑ Open (Planned):
- ❑ Revision from_____: □ Conversion to:
- ❑ Revision of:

- ❑ Adjustable Gastric Banding (LAP-BAND®, or REALIZE®)
- ❑ Vertical Banded Gastroplasty (VBG) (Marlex mesh, or other non-adjustable band)
- ❑ Vertical Banded Gastroplasty (VBG) (With LAP-BAND®, or other adjustable band)
- ❑ Vertical Gastroplasty (Without banding)
- ❑ Sleeve Gastrectomy (_____ Bougie || □ With □ Without Short-Segment 40 Bougie “Waistline”)
- ❑ Proximal Roux-en-Y Gastric Bypass (PRNY)
- ❑ Non-Adjustable Gastric Band without Vertical Gastroplasty (Silastic, Mesh, Gortex or other)
- ❑ Biliopancreatic Diversion (BPD) with Duodenal Switch (DS) (Possible Scopinaro)
- ❑ Biliopancreatic Diversion without Duodenal Switch (Planned Scopinaro)
- ❑ Vagotomy and Pyloric Drainage (Pyloroplasty or Pyloromyotomy)
- ❑ Cholecystectomy
- ❑ Appendectomy
- ❑ Lysis of Adhesions (Possible)
- ❑ Liver Biopsy
- ❑ Hiatal Hernia Repair with Fundoplication or Omental Fat Wrap (Possible)
- ❑ Hiatal Hernia Repair without Fundoplication (Possible)
- ❑ Esophagogastroenteroscopy (Possible)
- ❑ Other Indicated Procedures
- ❑ 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).

- ❑ Roux Limb Length: _____ or not measured/dependent.
- ❑ Biliopancreatic Limb Length: _____ or not measured/dependent.
- ❑ Common Channel Length: _____ or not measured/dependent.

_____
Patient’s Initials

I understand that intra-operative findings or anatomic deviations secondary to previous surgeries or congenital variance may necessitate the alteration of the procedure or the use of an alternative procedure. In some instances, using standard limb lengths for a procedure may pose a potential problem from a safety, feasibility or technical standpoint, and 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 require 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, which is commonly defined as being 100 lbs overweight or having a Body Mass Index (BMI) of greater than or equal to 40, or a BMI of 35-39 with at least one major comorbidity, or condition commonly associated with morbid obesity. If my BMI falls out of this range, I understand that I am proceeding with surgery for alternate reasons, which I have discussed with my surgeon and I have chosen to proceed of my own volition.

I have reviewed drawings/illustrations of each of the bariatric operations offered by my surgeon. These illustrations clearly demonstrated to me the main characteristics of each operation, the differences between operations, and the relative advantages and disadvantages of each procedure. I understand these options to the best of my ability. I have had a chance to describe to the surgeon my eating habits and behaviors that led to my being overweight, as well as my medical and surgical history. Through my discussions with the surgeon, he has helped me to come to my own 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, possible complications, 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 that I will continue to require personal responsibility for my weight loss efforts in order to maximize my success and ensure long term favorable outcomes.

I understand the following definitions and facts. I understand that some of these terms may not be applicable to the surgery I have chosen:

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

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

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

- 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 (beginning of the colon). This is the segment where complex proteins and fats and carbohydrates are best digested after surgery. The length of this segment contributes to the amount of malabsorption of a given procedure.

- Band: A strip of tissue, mesh, tube or device that is wrapped around the stomach, 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).

- 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.

_____

Patient's Initials

- Staple Line: A row of staples fired into bowel or stomach by a stapling device. A staple line can be within an anastamosis, in a partition, at a divided bowel end, or along the stomach. 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:

- Dumping Syndrome: A complex of symptoms that usually occurs with concentrated 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: faintness, weakness, palpitations, loss of consciousness, nausea, vomiting, hypotension (low blood pressure), sweating, diarrhea of mild to explosive nature, cramps, pain and other symptoms.

- 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 esophageal cancer, ulcerative or erosive esophagitis and/or stricture. Medication therapy may or may not control these symptoms.

- 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 anti-emetics 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).

- Re-Learning to Eat: As a necessity, 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 and they receive extensive counseling on this issue both pre- and post-operatively.

Alternatives:

- I attest that all alternatives currently available and in common practice in the United States have been explained to me in exhaustive detail in both a discussion group setting and individual consultation, where I have had ample opportunity to ask questions.
- I have asked all the questions that I wished to ask and all questions have been answered in a satisfactory manner.
- I fully understand all alternatives, risks, and benefits of each operation offered by my surgeon.
- I also attest that I have personally taken time to validate the understanding that I obtained from my surgeon and the team of Advanced Bariatric Services, with other sources such as the American Society of Metabolic and Bariatric Surgery, other society internet web sites, and other peer-reviewed sources, publications, and pamphlets. I understand that not all such sources have been provided by Advanced Bariatric Services. I attest that it is my responsibility to have obtained this additional information and that I have done so.
- I 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 understand that some comments or information on such sites can be false, incorrect, or misleading, and I attest that no such site has been condoned or validated by my surgeon or Advanced Bariatric Services.

I certify that the staff of Advanced Bariatric Services and Dr. Elariny have thoroughly explained the details of the procedure that I have chosen, and that I comprehend this explanation and have demonstrated this comprehension through discussions with my surgeon. My surgeon and the staff of Advanced Bariatric Services have informed me in detail 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, the surgeons of Advanced Bariatric Services will do everything possible to perform the procedure in a laparoscopic fashion 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).

_____

Patient's Initials

I understand that my current weight poses significant risks for shortening my life and/or causing or worsening the severity of various associated disease states such as hypertension (high blood pressure), diabetes, high cholesterol, stroke, arthritis in my lower extremities and back, gallbladder/liver pathology, shortness of breath and fatigue, stress urinary incontinence (leaking urine with straining), sleep apnea, some cancers, 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 at the beginning of this consent, various diets and weight-reducing plans with or without the use of medications, exercise regimens, psychological or psychiatric therapy, and other regimens. I have made numerous attempts at permanent weight loss in the past, all without long-lasting success, and I believe that weight loss surgery will assist me in my weight-loss goals.

I understand that there is no plan to reverse this operation in the future and it is therefore considered to be permanent.

I understand that this is a surgical procedure and it is not without possible technical risks. 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; this may possibly lead to a fistula formation requiring long-term care or additional surgery

2) Narrowing or stricture of any anastamosis causing an obstruction which may require dilatation or even repeat surgery

3) Bleeding into the upper gastrointestinal tract, or freely 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 (especially if I am not following directions concerning what and how much to eat or drink after the operation)

5) Infection in my incision, inside the abdominal cavity, or of any foreign object (Band, mesh)

6) Blood clots in my legs which could break loose and travel to my lungs causing a pulmonary embolism (especially if I am less active after the surgery than I have been instructed to be)

8) A hernia through the incision or internally

9) Injury to other internal organs, which may require repair or excision to correct, or may be unnoticed during the time of initial surgery

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.

11) Regarding the LAP-BAND or similar such devices, I have been counseled on the possible risks of band erosion, band slippage, port-site and/or tubing complications

12) Gastroesophageal reflux disease

13) Gallstone formation or bile stasis

14) Persistent nausea or vomiting or food intolerance

15) Nutritional/metabolic deficiencies or complications, chronic fatigue, hair loss

16) Ulcers (especially if I smoke, drink alcohol, or take NSAIDs or similar such drugs)

17) I am aware that I may have steatorrhea (presence of excess fat in stool) and greasy, foul smelling stools, altered bowel habits, or increased bloating or flatulence, particularly with malabsorptive procedures

18) Esophageal perforation or injury

19) Finally, I am aware that it is possible that under the very worst of circumstances, these complications could result in my death or permanent debilitating medical condition, 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 future 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.

_____

Patient's Initials

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 weight loss 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 Bariatric Services 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. I understand that surgical trainees including a fellow in bariatric surgery and residents in surgical training may be an integral part of my care, and agree to their participation as deemed fit and overseen by my surgeon.

If I am female, sexually active, and still have that capability, I understand that there is an increased chance of becoming pregnant after my surgery, 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 oral contraceptives are not reliable for contraception after weight loss surgery, 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. 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.

I have also been informed about the possibility of the "dumping syndrome" from eating sweets after some weight loss 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 Bariatric Services 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. 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 Bariatric Services 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.

_____

Patient's Initials

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 if this is a revisional procedure, the risks of the procedure are even further increased.

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.

_____ _____

SIGNATURE OF PATIENT DATE SIGNED

_____

WITNESS TO PATIENT'S SIGNATURE

_____ _____

SIGNATURE OF SURGEON DATE SIGNED