Metabolic and Bariatric Surgery Checklist

Please contact our team for additional information at ***(774)227-8482 x 802 or FAX reports to (510) 369-3816***

Patient's Name: _____

DOB and MRN#:_____

Type of surgery to be performed: _____

Abbreviations: **< =** less than; **>** = more than; **WNL** = Within Normal Limits; **SWL** = Surgical Weight Loss

Surgeon Evaluation:

I have ordered the following lab work, tests & studies: *(complete below - make notations as needed if labs/tests/studies were completed)*

- ❑ **Complete Metabolic Panel** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Complete Blood Count** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Vitamin/Mineral Panel** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Coagulation Panel** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Liver Function Panel** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Iron Studies Panel** (date completed): _____
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ❑ **Thyroid function** - TSH (date completed):_____
  - ☐ Result WNL
  - ☐ Abnormal result, patient referred to PCP for possible medication needs

- ❑ **Hemoglobin A1C –** result was **8.5 or greater** (date completed): _____
- ❑ **Hemoglobin A1C –** result was **less than 8.5** (date completed): _____

Patients must demonstrate an A1C of less than 8.5 to qualify for a bariatric surgery date.

- ☐ ***H. Pylori* screening** – *stool sample required-* (date completed): _____
- ❑ Results were **WNL**
- ❑ H. pylori **PRESENT** and treatment was completed on (date): _____
- ❑ **Eradication verified** on (date): _____

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Radiologic and Other Studies: *(Please **FAX** report to office at **510-369-3816**)*

☐ **Endoscopy/EGD** completed on (date):_____

- ❑ EGD/Endoscopy **not indicated**
- ❑ Results were WNL on (date): _____
- ❑ H. pylori present and treated on (date): _____
- ❑ **Eradication verified** on (date):_____
- ❑ **Other results** outside of normal limits as follows**:**_____

_____

_____

☐ **Ultrasound – Abdomen Right Upper Quadrant** IF symptomatic and gallbladder still present, AND/OR, in presence of elevated liver function tests: screen for fatty liver and cholelithiasis (gallstones); completed on date):_____

- ❑ Ultrasound **not indicated**
- ❑ Results were WNL on (date): _____
- ❑ Results were outside of normal limits as follows**:**_____

_____

_____

❑ **Upper GI Series** completed on date):_____

- ❑ Upper GI study **not indicated**
- ❑ Results were WNL on (date): _____
- ❑ Results were outside of normal limits as follows**:**_____

_____

_____

❑ **Cardiac Risk Stratification** (ACC/ AHA guidelines): e.g., ECHO if indicated

_____

_____

☐ **OTHER TESTING (studies, tests and completion dates):**_____

_____

_____

_____

_____

_____

_____

- ❑ Additional studies/tests **not indicated**
- ❑ Results were WNL on (date): _____
- ❑ Results were outside of normal limits as follows**:**_____

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_____
_____
_____

☐ **TREATMENT PLAN for abnormal labs, tests or studies noted:**

_____
_____
_____
_____

☐ ***Full H&P of systems completed, comorbidities optimized with final approval given by bariatric surgeon; patient cleared to proceed to surgery.***

Surgeon Signature: _____ Date: _____

Nutrition Evaluation: *(See also - Nutrition checklist):*

☐ Patient completed a **minimum of 4 nutrition visits** with the **registered dietitian** and has met all other requirements of the nutrition checklist:

❑ Dietitian has conducted an ACSM Exercise Pre-participation Screening.
❑ Patient has met **at least 75%** of the required preoperative weight loss goal.

☐ Patient understands weight goal for day of surgery = _____ pounds.
❑ 5% Total Body Weight (TBW) loss for BMI up to 50.
❑ Otherwise to achieve BMI < 50.

From a nutrition standpoint this patient is:

☐ An appropriate candidate for bariatric surgery who has demonstrated understanding of and willingness to follow the prescribed bariatric diet, mindful eating and drinking practices, prescribed exercise program and prescribed **lifetime** vitamins, minerals and other recommended supplements.

☐ Not recommended for bariatric surgery at this time for the following reason(s):

_____
_____
_____

Registered Dietitian Signature: _____ Date: _____

Behavioral Health (BH) Evaluation: *(See also – BH checklist):*

☐ Patient completed a **minimum of 2 behavioral health visits** with the behavioral health provider and has met all other requirements of the behavioral health checklist:
- ☐ Patient has ***signed and understands all agreement contracts*** (general patient contract for the surgical weight loss program; tobacco/smoking cessation contract; substance use/abuse cessation contract)
- ☐ Patient has no behavioral health contraindications to have bariatric surgery

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- ☐ There are no absolute behavioral health contraindications to bariatric surgery:_____
  _____
  _____
  _____

- ☐ Patient is not recommended for surgery at this time and should have the following behavioral health condition(s) further optimized **prior to** surgical clearance:
  _____
  _____
  _____

Behavioral Health Provider Signature: _____Date: _____

Support Groups and Classes: (*You must attend **all** of the following groups to qualify for an assigned surgery date. Please call to reschedule any missed appointments.)*

1. **SWL Group Information Seminar** (date): _____
   Facilitator's Signature: _____
2. **Pre-Operative Panel** (date): _____
   Facilitator's Signature: _____
3. **Steps to Success** (date):_____
   Facilitator's Signature: _____
4. **Being Successful** (date): _____
   Facilitator's Signature: _____
5. **Mindful Eating** (date): _____
   Facilitator's Signature: _____

Obstructive Sleep Apnea (OSA) Screening and Management

"STOP-BANG" Screening Quiz

- ☐ Patient's quiz score was: __/8__ on (date): _____
- ☐ Score of less than 3 – **No sleep study indicated**
- ☐ Score of 3 or more – **Sleep study indicated**

Facilitator's Signature: _____

Sleep Study: (***Please fax report(s) to the office for review** at **510-369-3816**).*

- ☐ Sleep Study completed and report received on (date):_____

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- ☐ Patient does NOT require referral to a sleep clinic provider/pulmonologist
- ☐ Patient has been referred to a sleep clinic provider/pulmonologist for obstructive sleep apnea evaluation and assessment for possible equipment needs.

Facilitator's Signature: _____

Sleep Clinic/Pulmonologist evaluation completed on (date):_____

- ☐ Sleep Clinic/Pulmonologist evaluation **not indicated**
- ☐ CPAP/BIPAP/APAP **not** recommended
- ☐ Circle one: CPAP/BiPAP/APAP **recommended**

Setting: _____

Sleep Clinic Provider Signature: _____ Date: _____

Patient Attestation:

Things to remember:

- If you haven't already, make sure all of your medications are crushable, liquid or chewable
- No NSAIDs after surgery
- No drinking through straws or chewing gum
- Avoid caffeine, alcohol, and carbonated beverages
- No estrogen (hormone replacement therapy, oral birth control) for two months before and two months after surgery due to risk for blood clots
- IUDs can be left in place as there is a significantly lower risk of blood clots associated with them compared to oral birth control
- Be sure to use alternative forms of contraceptive to avoid pregnancy for 2 years after surgery, if applicable, as fertility often improves with weight loss

Prepare Mentally and Emotionally for Bariatric Surgery:

- ☐ I understand the surgery I will be having. I have read all information given to me by the Healthier Body Institute staff.
- ☐ I understand that I should abstain from drinking **any** alcohol pre-operatively; abstain from drinking **any** alcohol for **2 years** post-operatively; and preferably, avoid alcohol for the rest of my life to maintain my surgical weight loss and avoid preventable health risks associated with use of alcohol after bariatric surgery.
- ☐ I can commit to the prescribed changes to my lifestyle, such as the new diet and exercise program.

Patient Attestation – *continued from page 6*

- ☐ I can commit to attending all **ongoing** recommended follow-up visits with my bariatric surgeon and dietitian **for my lifetime**. I understand that this ongoing, lifetime follow-up is my **best defense** against:

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a) post-surgery complications;
b) vitamin/mineral deficiencies that could have *serious and even permanent effects* on my health;
c) not meeting my surgical weight loss goals, and
d) experiencing weight regain after bariatric surgery.

- ☐ I discussed having bariatric surgery with my family and/or friends.
- ☐ I know where to get the information and support I need for this journey.
- ☐ I passed my Pre-Operative Bariatric Surgery Quiz on (date):_____

Patient Signature: _____ Date: _____

Quiz Facilitator's Signature _____ Date: _____

Preparation with Lifestyle Changes for Bariatric Surgery:

- ☐ I have started changing my diet to align with recommendations from my dietician.
- ☐ I have followed an exercise program as recommended by my team: walking as tolerated, swimming, etc.
- ☐ I have met at least 75% of my pre-surgery weight loss goal as directed.
- ☐ I have consistently completed and presented my food and exercise logs as required by my dietitian and surgeon.
- ☐ I have stopped smoking, vaping, or using other tobacco or marijuana/THC products since enrolling in the program (if I ever used these products at all).
- ☐ I have stopped consuming alcoholic beverages since enrolling in the program (if I previously consumed alcoholic beverages).
- ☐ I understand that I must adhere to a **2-week pre-surgery** "liver shrinking" diet, if indicated.

Patient Signature: _____ Date: _____

Patient's Name _____

DOB and MRN#: _____

Type of surgery to be performed: _____

**** Primary Care Provider will determine if the following workup is needed:**

- ☐ Primary Care Provider to ensure that health maintenance issues are addressed prior to surgery (e.g., cancer screenings including mammograms and colonoscopies as indicated; known health conditions such as diabetes, hypertension and anemia are being optimally managed).

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_____
_____
_____
_____

- ☐ Patient meets **HbA1c** goal of < 8.5 to qualify for bariatric surgery.
- ☐ **EKG required** for: male age > 40, female age > 50, and/or sedentary lifestyle **done on** (date): _____
  - ☐ Results:
    _____
    _____
- ☐ How long has the patient had **Class I or higher** obesity?
  _____
  _____

To be completed by Primary Care Provider prior to exercise assessment with registered dietitian:

Regarding EXERCISE, this patient:

- ☐ Has **no restrictions** for physical activity and is cleared to start a walking program or other exercise program as required prior to bariatric surgery.
- ☐ Has the following restrictions or limitations for physical activity:
  _____
  _____
  _____
  _____
- ☐ These conditions/limitations/restrictions are being optimally managed with the following:
  _____
  _____
  _____
  _____

Primary Care Provider Recommendations:

- ☐ I do not recommend this patient for bariatric surgery at this time for the following reason(s):_____
  _____
  _____
  _____

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- ☐ I **recommend** this patient for bariatric surgery and attest that all health problems are being optimally medically managed in preparation for major surgery.

- ☐ ***Full H&P of systems completed, comorbidities optimized with final approval given, clearing patient to proceed with an assigned surgery date.***

PCP Signature: _____ Date: _____

Patient's Name _____

DOB and MRN#: _____

Type of surgery to be performed: _____

**** Specialist clearances for bariatric surgery *if indicated*:**

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- ☐ Cardiology
- ☐ Endocrinology
- ☐ Gynecology
- ☐ Hematology
- ☐ Nephrology
- ☐ Pulmonology
- ☐ Other (list):

_____

_____

Provider will determine if additional workup is needed to *optimize health condition(s) applicable to area of specialist's management* in preparation for major surgery.

Provider Recommendations:

- ☐ I do not recommend this patient for bariatric surgery at this time for the following reason(s):_____

_____

_____

- ☐ I **recommend** this patient for bariatric surgery and attest that all health problems/conditions *applicable to my area of specialty management* are being optimally medically managed in preparation for major surgery.

- ☐ ***Full H&P of systems completed with final approval given by specialist, clearing patient to proceed with an assigned date for bariatric surgery.***

Specialist Signature: _____Date: _____

- ☐ **Additional Notes (*if needed*):** _____

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