Community Bariatric Surgeons
Email: cconwell@ecommunity.com

PATIENT INFORMATION PROFILE

Keith E McEwen MD

9669 East 146th Street
Suite 340
Noblesville IN 46060-4303

Telephone: 317-621-2500 Fax: 317-621-2503

OPTIONS:
Scan packet to: cconwell@ecommunity.com
Fax packet to: 317-621-2503

Before submitting Precertification paperwork to an insurance carrier, we must complete the following appointments as required by all insurance carriers (some carriers require additional items):

1) Surgeon Consult
2) Initial Dietary Consult
3) Initial Psychological Consult

Medicaid Insurance (HIP, Traditional) requires six month supervised weight loss prior to submission, medical clearance, and smoking cessation for 6 months.

We provide **6 months** of Supervised Weight Loss Classes to help patients meet insurance and program guidelines at no cost to our patients. Longer than 6 months or in-depth individual counseling may be additional.

OUR STAFF WILL VERIFY BENEFITS WITH YOUR CARRIER AND HELP YOU NAVIGATE TO MEET THE REQUIREMENTS AND INFORMATION THAT YOUR CARRIER PROVIDES TO US.

Legal Last Name _____First Name_____Date Of Birth_____

Preferred Name to Be Called: _____ Age: _____ Email Address: _____

ADDRESS_____ CITY_____STATE_____ ZIP _____

HOME PHONE_____ WORK PHONE_____ EXT_____ CELLPHONE_____

PATIENT'S SOCIAL SECURITY#_____ **PATIENT'S** EMPLOYER_____

PRIMARY Physician's Name: _____ Physician's Telephone # _____

SPOUSE OR Guarantor's Name (AS APPLICABLE) _____ DATE OF BIRTH_____

Guarantor's Social #if necessary for insurance: _____EMERGENCY CONTACT & NUMBER (NOT LIVING WITH YOU) _____

*I understand that community bariatric surgeons. (also keith e. mcewen, m.d, Community Hospitals Indiana.) will contact me at the above telephone numbers regarding appointment scheduling, test results, and other information, **unless i request**, in written format, an alternative method to be used.*

INSURANCE INFORMATION: If you want us to verify benefits- we need this portion completed. We can scan card at office.

INSURED'S (SUBSCRIBER) INFORMATION (PERSON CARRYING INSURANCE ON ABOVE PATIENT)

INSURED'S NAME (Subscriber) _____ DATE OF BIRTH_____

SOCIAL SECURITY#_____ RELATIONSHIP: SPOUSE PARENT GUARDIAN

INSURED'S EMPLOYER _____ INSURED'S WORK# _____

EMPLOYER'S ADDRESS_____ CITY_____ ST_____ZIP_____

INSURANCE NAME _____ Insurance ID#_____ Group Number: _____

MEMBER SERVICES Telephone#_____ Precertification Telephone #_____

IS THERE **SECONDARY/SUPPLEMENTAL** INSURANCE? YES OR NO

INSURED'S NAME (Subscriber) _____ DATE OF BIRTH_____

INSURANCE NAME _____ Insurance ID#_____ Group Number: _____

MEMBER SERVICES Telephone#_____ Precertification Telephone #_____

Please note- smoking cessation is required upon entering the program. Many insurance carriers require a nicotine test. Please discuss this with our nurse or dietitian.

I hereby authorize my insurance carrier, Medicare, supplemental carrier, or worker's compensation carrier to pay COMMUNITY HOSPITAL INDIANA for services rendered to me. I authorize COMMUNITY HOSPITALS OF INDIANA to release my personal health information to only those parties entitled to my information such as, other physicians, insurance carriers, Medicare and treating facilities. I read or have been offered or given a copy of COMMUNITY HOSPITALS OF INDIANA, HIPAA/privacy act compliance form effective 4/1/2002.

NIH guidelines for Lap Band- YOUR INSURANCE CARRIER MAY HAVE OTHER STIPULATIONS.

BMI of 30-34 with 1 co-morbid condition. (Hypertension, sleep apnea, diabetes, cardiac issues)

BMI of 35 or above with no co-morbid conditions.

Orbera BMI of 30-39 only – Orbera IS NOT covered by insurance

Patient Signature _____ Date_____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____ First Name _____ Date Of Birth _____

Health Information

Do you have ALLERGIES? Yes □ No □

If Yes, list allergy & the reaction (breathing, swelling, rash, etc)

_____

_____

_____

_____

History of Previous Surgeries Yes □ No □

If yes, list:

_____

_____

_____

_____

Approximate Height _____ *Staff total BMI*

Approximate Weight _____

List of Medications: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Alcohol Abuse (within past 12 months	Yes □	No □	Arthritis	Yes □	No □
Anemia	Yes □	No □	Back pain	Yes □	No □
Asthma	Yes □	No □	Hip Pain	Yes □	No □
Autoimmune Disease	Yes □	No □	Knee Pain	Yes □	No □
Lupus	Yes □	No □	Foot pain	Yes □	No □
Crohn's Disease	Yes □	No □	Lower Leg Swelling	Yes □	No □
MS (multiple sclerosis)	Yes □	No □	History of Stroke	Yes □	No □
HIV	Yes □	No □	History of Nausea with Anesthesia	Yes □	No □
Rheumatoid arthritis	Yes □	No □	History of problems with Anesthesia	Yes □	No □
Infectious Disease	Yes □	No □	Kidney or Renal Disease	Yes □	No □
Bleeding and/or clotting Disorder	Yes □	No □	Neurological disease	Yes □	No □
Clot (PE) Pulmonary Embolism	Yes □	No □	Urinary Disorder	Yes □	No □
COPD	Yes □	No □	History of Depression	Yes □	No □
Cirrhosis of the Liver	Yes □	No □	History of Mental Disorder	Yes □	No □
Diabetes	Yes □	No □	History of Physical Disability	Yes □	No □
Type 1	Yes □	No □	History of Illicit Drug Use	Yes □	No □
Type 2	Yes □	No □	**Portal Hypertension**	Yes □	No □
History of Diabetes when Pregnant	Yes □	No □	Seizure History or Epilepsy	Yes □	No □
Esophageal or Gastric Varices	Yes □	No □	*Sleep Apnea*	Yes □	No □
GERD or REFLUX	Yes □	No □	Do you use a CPAP	Yes □	No □
Heart Disease	Yes □	No □	Steroid use in past 2 months	Yes □	No □
Hepatitis or Liver Disease	Yes □	No □	TB (tuberculosis)	Yes □	No □
High Blood Pressure (HTN)	Yes □	No □	**Tobacco Use current:**	Yes □	No □
High Cholesterol or Lipids	Yes □	No □	**smoking cessation is required		
History of Cancer	Yes □	No □	If prior use: #PPD? _____ How Long? _____		
History of Chronic Pancreatitis	Yes □	No □	ULCER history (gastric or Duodenal)	Yes □	No □

Staff Notes for Positive Answers

Patient Signature _____ Date _____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

GASTROESOPHAGEAL REFLUX / INDIGESTION HISTORY/GERD

Do you have a history of heartburn or indigestion? Yes No Details: _____

If yes, how often do you have reflux during the day? Daily Weekly Occasionally

If you have reflux at night, how often, Nightly Weekly Occasionally

What aggravates or causes your reflux? Details: _____

Do you have difficulty swallowing? Yes No Details: _____

Does food ever become stuck? Yes No Details: _____

Do you suffer from a persistent cough at night? Yes No Details: _____

Please list any treatments you may use for reflux/heartburn or indigestion: _____

Have you had an ENDOSCOPY (scope) recently? Yes No Details: _____

SOCIAL PROFILE

Children/Ages: _____

Support persons/friends: _____

FAMILY HISTORY	MOTHER	FATHER	BROTHER/ SISTER	CHILD	NO FAMILY HISTORY
Asthma					
Diabetes					
Fatty liver disease (NAFLD)-non-alcoholic					
Gallstones/gallbladder disease					
Heart Disease					
Hypertension					
Obesity					
Osteoporosis					
Snoring/sleep Apnea					

FEMALES ONLY: (please circle)

Have you had a tubal ligation? Yes or No

Do you have regular periods (26 - 33 days)? Yes or No

Do have problems with excessively heavy periods? Yes, or No

Have you suffered from excess body hair or acne? Yes or No

Have you had a hysterectomy? Yes or No

Do you currently have problems with infertility? Yes or No

Have you had difficulty in conceiving in the past? Yes or No

Do you have polycystic ovarian disease PCOD? Yes or No

Where did you hear about our program or DR. McEwen?

TV program_____ Internet: _____

Facebook_____ Friend: (please include name) _____

Newspaper or Brochure_____ Physician: _____

If a physician referred, please complete Referring Doctor: _____

Telephone#: _____ Address: _____

City:_____State_____Zip_____

What has been your biggest obstacle to moving forward with Lap Band System® or Bariatric Surgery: (circle all that apply):

Fear of Weight Loss Surgery

Fear of "never being able to eat and enjoy"

Awareness of a person that had a "bad" result

Stigma of Weight Loss Surgery (afraid others will judge your decision)

Lack of Physician Support and/or Lack of Family Support

Insurance coverage and/or financial concerns

Fear of Failure

Patient Signature _____ Date_____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

PATIENT AGREEMENT TO PARTICIPATE- Behavior Contract

Bariatric surgery is major step towards improving your health and wellness. This agreement outlines the minimum requirements necessary to undergo bariatric surgery and be successful in your weight loss journey. Your surgery and overall success depends on your compliance with the following program requirements:

1. **We consider your day of consult as the first step in making a commitment to weight loss.** You will be working closely with the bariatric team to help you through this process. If you fail to lose weight prior to surgery, we may determine you need further education and/or additional therapy before proceeding.
   Per our program requirements, industry standards, and many insurance policies, we reserve the right to postpone your surgery if weight gain occurs.

2. **Complete all required appointments, pre-op classes, and education.**
   - The pre-op nutrition and behavioral skills classes will provide vital information including nutrition, exercise, and behavioral modifications. Many are at NO COST and on many different days during the month for your convenience. They are a requirement for insurance approval and program requirements.
   - You must commit to attending at least (2) TWO REGULAR support groups prior to surgery.
   - Please give 24 - hour notice if you need to cancel an appointment. If you cancel late (within 24 hours) or do not show for an appointment two (2) times, you will be discharged from our program.

3. **Follow the nutrition and exercise guidelines prescribed by the bariatric team**. Understand that you will be on a weight loss regimen, and you must demonstrate appropriate weight loss efforts through compliance with the recommended guidelines. You must complete a food and activity log. Your log will be reviewed at appointments. You must commit to participation in daily physical activity as designated by the bariatric team.

4. We REQUIRE a 2% weight loss in addition to any BMI requirements. Our RD (Registered Dietitian) will provide you with these recommendations in writing at your initial meeting.

5. **Commit to understanding and completing the requirements of the clinical psychologist. If recommendations are made, a** copy of these recommendations will be given to you and it is your responsibility to complete all recommendations prior to being given a surgery date. In addition, you must comply with the recommended behavioral modifications learned in class.

6. **If you use tobacco products, please stop now. Our program, as well as many insurance policies, mandate that patients are tobacco free for at least three to six months prior to surgery.** Many carriers require lab screenings. If you have positive results, your insurance will deny approval and your surgery postponed. If you need assistance, please consult your primary care physician or the bariatric team for further information on cessation programs.

7. If you take illegal substances, many carriers require screenings. Please discuss with our clinical staff.

8. The Lap Band System requires routine follow up care. It is a lifelong commitment to have weight loss surgery.

9. Please acknowledge that you will be able to follow up monthly for the first 12 months then every quarter to six months depending on physician recommendations as long as you have a Lap Band System.

I understand that if I do not complete and comply with the requirements made by the bariatric team, I could jeopardize my health, weight loss success, or my suitability as a candidate for surgery. I understand that bariatric surgery is only a tool and will not guarantee my weight loss. I understand that these requirements continue as a lifetime commitment. I accept personal responsibility for my success. I understand my results will be a product of using the tools that I will be given. I understand and agree that if I have difficulties, I will initiate follow up as recommended by the bariatric team.

By signing below, you are agreeing to proceed with our program and that you understand your participation and commitments.

Patient Signature _____ Date_____
Printed Name _____
Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

WEIGHT LOSS HISTORY ATTEMPTS **circle please**

Adipex	Atkin's	Cabbage Soup	Dexatrim
Gloria Marshall	Grapefruit	Herbalife	Hoodia
Jenny Craig	Low Calorie	Low Fat	Mayo Clinic
Meridia	NutriSystem	Optifast	Overeaters Anonymous
Physician Weight Loss	Prozac	Redux	Phentermine
Richard Simons-Deal a meal	Slim Fast	South Beach	Fen Phen
Sugar Busters	Suzanne Somers	Weight Watchers	Xenical
Zone Diet	LA weight loss	Tburner	Other: _____

What was **the most weight** that you lost or range of Weight loss with the before mentioned methods? _____

_____

How long has your weight been a problem: _____

What is your personal weight loss goal: _____

Do you have any food allergies or intolerances: _____

Have you had any nutritional deficiencies in the past: _____

Do you currently take any vitamins, minerals, and/or herbal supplements? _____

_____

Current Intake:

Number of Meals per day: _____

Snacking Behavior: _____

Type of Beverages: _____

Eating out- Frequency and Location: _____

Cravings and/or trigger foods:_____

Exercise:

Type, frequency per week, and duration: _____

What is patient perception of exercise: _____

Email Address:_____

Staff Use Only: Dietary Consultation Date: _____ Height_____ Weight_____ Age:_____ BMI____

Areas to Change:

3 meals per day

Snacking

Exercise

Beverages- Carbonated Caffeinated Alcohol

Patient's 2% goal _____ Patient's BMI goal if necessary _____

Additional Items: _____

_____

_____

RD Signature: _____ Date: _____

Patient Signature _____ Date_____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*give this to your Primary Care Physician

I give my permission to release my medical information to Community Bariatric Surgeons, Community Hospital Indiana, and Keith E. McEwen, M.D.

Release the following information**:**

- ☐ The medical record pertaining to weight loss:
  - One weight (preferably the highest) for the PAST 5 YEARS
  - Any Consecutive Weight Loss appointments of counseling for weight, and/or use of prescription weight loss drugs
  - Pertinent Lab Results from the last 12 months (A1C, Thyroid, Glucose, ETC)
  - EKG or Stress Test from last 12 months
  - Cardiac Results or Studies
  - Diabetic Results or Counseling
  - Any Endoscopy from the last 3 **years**
- ☐ Other _____

I hereby authorize release of such information to the above to include any and all medical records concerning my medical history, physical condition, diagnoses, treatment and/or prognosis, including X-rays and other diagnostic reports, as well as, any information contained in my medical reports or records that relate to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous or any communicable diseases, including AIDS or tests for infection with HIV, any other information related to my treatment.

This information is being requested for the following purpose:

Appointment with Dr Keith McEwen (Community Bariatric Surgeons) in regards to Weight Loss Surgery (Lap Band System®)

This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows:

Do not release information contained in my record regarding:

_____

Patient Name:_____Date of Birth: _____
Release only records for the dates of _____through_____

Patient/Consenting Party Signature: _____Date: _____
(Guardian or Legal Representative if patient under 18 years old)

A photocopy of a signed authorization is acceptable, providing that it is apparent that following the photocopying of the authorization on line the signature or the date is not added. This authorization is valid for sixty (60) days after the date of this request is made, unless otherwise stated. I understand this consent can be revoked at any time to the extent that disclosure is made in good faith has already occurred in reliance on this consent**.**

Telephone: 317-621-2500 **Fax: 317-621-2503**

Mailing Address:

Community Bariatric Hamilton-Keith McEwen MD
9669 East 146th Street #340
Noblesville IN 46060

Patient Signature _____ Date_____
Printed Name _____
Staff Signature _____ Date _____