Surgical Treatment of Morbid Obesity

BARIATRIC (WEIGHT LOSS) SURGERY PROGRAM
PROSPECTIVE AND NEW PATIENT INFORMATION

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Bariatric Surgery Interested Patient Checklist

To Do

☐ Read Introduction letter
☐ Read Surgical Treatment of Morbid Obesity
☐ Complete the Bariatric Surgery Quiz
☐ Complete the Diet History form
☐ Complete the Department of Surgery New Patient Information form and Review of Systems
☐ Blood Product Release Form
☐ Complete the Demographic / New Patient Information Form
☐ Return the completed Bariatric Surgery Quiz, Diet History Form, Kirklin Clinic Department of Surgery New Patient Information and Review of Systems form, and Demographic Form to our office.

Additional items in this packet

☐ Medical Weight Loss Progress Note for your primary care physician to fill out at each of your monthly visits during you mandatory preoperative physician directed diet (you will need to make 6 copies of this form prior to filling it out)
☐ Body Mass Index Table. You can also calculate your BMI using any of numerous online versions of free BMI calculators
☐ Fresh Beginnings Support Group and Bariatric Community Seminars schedule
☐ Directions to Highlands
☐ Approximate weight loss surgery private pay fees
Introduction

Obesity is a very common condition affecting between 20 and 30% of the U.S. population. In fact it is the most common nutritional disorder in our nation. A person is considered obese when they are about 30% over their ideal body weight. The term "morbid obesity" is used to describe people who are about twice the weight they should be or 100 pounds overweight. A formula based upon height and weight is used to determine if someone has morbid obesity:

\[ \text{Weight in Kg/}(\text{Height in meters})^2 = \text{Body Mass Index} \]

If this number, the Body Mass Index (BMI), is 40 or greater, or 35 - 39 with certain other health problems due to obesity, a person is considered morbidly obese and may be a candidate for surgery.

Rationale for Treatment of Morbid Obesity

A number of health problems are directly related to obesity. They include atherosclerosis affecting the heart and other vessels, congestive heart failure, hypertension, obstructive sleep apnea syndrome, and severe arthritis especially of the back, hips, and knees due to the tremendous weight these joints have to bear. Adult onset diabetes is often brought on by obesity. In fact up to 50% of morbidly obese individuals have diabetes. Diabetes is a leading risk factor for heart disease and a leading cause of premature death. Because fat cells affect the metabolism of estrogen, many morbidly obese females have irregular periods or may even have trouble becoming pregnant. Obesity is also a risk factor for the development of uterine cancer. In addition to the known health risks, morbidly obese people may suffer from other less obvious but no less troubling psychosocial problems including diminished career opportunities, social maligning, and difficulty in public places such as mass transit vehicles and airplanes.

If we plot the incidence of these and other obesity related conditions as a function of weight, we would see that as the average weight of a population increases, so does the incidence of these co-morbid conditions. Likewise, if we plot the mortality rate of a population as a function of their average weight, we see it increases. When the average weight of the population reaches about twice the ideal body weight, i.e., the point at which we say someone is morbidly obese, the two curves we
plotted begin to change exponentially. Simply put, the problems associated with obesity begin to mount rapidly when a person enters the realm of morbid obesity.

While weight loss may not correct all of these problems, it has been shown to improve many. In this era of preventative medicine, we realize that the best “treatment” for heart disease is to prevent its occurrence in the first place. Diabetes and hypertension control are improved with weight loss. In fact some individuals who require insulin or other medication for diabetes no longer require it after losing weight. Arthritis sufferers generally have less pain after losing weight, and those individuals who do not yet have arthritis may be able to prevent it by losing weight.

But, while weight loss improves the outlook of many individuals, some actually have difficulty adapting to their “new bodies.” We have seen familial and marital problems develop likely as a result of families and friends thinking their loved one has changed, and indeed they have.

This is not “cosmetic” surgery. The overall goal of surgery is to improve your health. And while we define success as losing 50% or more of your excess body weight, not everyone achieves that. In other words, surgery is not successful for all patients.

**Treatment Options**

Many patients claim, “I don’t eat too much,” and while the literature suggests obese people may indeed be more efficient with the calories they ingest, for the most part, you simply cannot be overweight without overeating. In general, obesity is best treated by taking in fewer calories than you burn. While this may sound simple, adhering to that dictum is difficult. The National Institutes of Health studies estimate the success of dieting for weight loss at about 3%. In fact, it may be lower than that for morbidly obese people. Diet pills seem to help somewhat, and perhaps a few more individuals are successful with these. However, regaining weight after stopping the diet pills often proves to be problematic.

Surgical treatment of obesity, called bariatric surgery, has evolved over the years. We currently perform both open and laparoscopic gastric bypass, laparoscopic adjustable gastric banding, and laparoscopic sleeve gastrectomy. The following information will provide you with an overview of each of these operations. This is considered required reading for entry into our bariatric program.

**Indications for bariatric surgery**

Only severely obese people (greater than twice their ideal body weight) are considered for surgical treatment. Otherwise, the expected risks may outweigh anticipated benefits. The *ideal* patient:

- clearly and realistically understands the surgical risks, benefits, and limitations of surgery, and how their lives may change after surgery
- has a quality of life that is severely impacted by their obesity
- is able to participate in treatment and commit to long-term follow up
• is at least 100 pounds over their ideal body weight, has a BMI of 40 or above, or has a BMI of 35 to 40 with associated medical conditions such as diabetes, obstructive sleep apnea syndrome, hypertension, or severe osteoarthritis secondary to their obesity
• has tried but failed non-surgical means of weight loss within the last year
• has been morbidly obese for at least 3 years
• is healthy enough to undergo a major elective abdominal operation
• has no contraindications for surgery as described below.

Contraindications or reasons to avoid weight loss surgery
Not every morbidly obese patient should undergo an operation. Some reasons an operation may not be advisable include:

• significant heart disease
• active peptic ulcer disease
• patients unfit for general anesthesia
• patient is not prepared to make necessary lifestyle and/or behavior changes
• active alcoholism
• active drug abuse
• hepatic cirrhosis with impaired liver function tests
• serious psychiatric disability
• patients in very poor overall health
• persons who feel they will achieve an absolutely normal weight, be made beautiful, or be able to enjoy eating after operation as before, i.e., unrealistic expectations
THE OPERATIONS

GASTRIC BYPASS

The operation creates a very small upper stomach pouch (less than one ounce) by transecting the stomach (See Figure). Ingested food passes out of the upper pouch through a small opening (anastomosis) into the intestine. The remaining portion of the stomach and the first part of the small intestine are bypassed. Thus, the operation is termed a "gastric bypass with Roux-en-y gastrojejunostomy." Food does not mix with the digestive enzymes secreted from the pancreas until it has travelled 4-6 feet downstream. If the gallbladder is diseased, it may be removed during the operation.

The operation is usually done with laparoscopic instruments through several small incisions. This technique involves inserting a video telescope into the abdomen through a small incision. Five additional similar size incisions are placed in the upper abdomen. The operation is then carried out using specialized instruments inserted through these incisions while the abdominal cavity is distended with carbon dioxide gas. This approach has the potential advantage of smaller incisions, less pain, quicker recovery, fewer wound complications, earlier discharge from the hospital, and less scarring, while potentially providing the same weight reduction as the traditional open approach.

Occasionally, gastric bypass must be done or converted to an open operation requiring an incision from the breastbone to just above the umbilicus in order to gain access to the internal organs. If for whatever reason, the operation cannot be safely completed using the small incisions, the abdomen will be opened, and the operation will be completed in that manner. Thus, not every patient is a candidate for the laparoscopic procedure. The surgeon will determine this during your initial visit and during the course of the operation.
Sleeve Gastrectomy

This is a newer procedure that induces weight loss by restricting food intake. Approximately 80% of the stomach is removed so that it takes the shape of a tube or "sleeve." This part of the procedure is not reversible. Sleeve gastrectomy induces weight loss through gastric restriction (reduced stomach volume). There also appears to be a reduction in appetite possibly due to decreased secretion of hormones from the excised portion of the stomach that normally stimulate hunger. The stomach that remains is shaped like a banana, and measures from 2-5 ounces (60-150cc) depending on the surgeon performing the procedure. The nerves to the stomach and the outlet valve (pylorus) remain intact with the idea of preserving the functions of the stomach while reducing the volume. By comparison, in a Roux-en-Y gastric bypass, the stomach is divided, not removed, and the pylorus is bypassed. Note that there is no intestinal bypass with a sleeve gastrectomy, only stomach reduction.

Like gastric bypass, sleeve gastrectomy is usually done laparoscopically, but rarely it may require conversion to an open procedure with a larger incision.
Adjustable Gastric Banding

The adjustable gastric band induces weight loss by reducing the capacity of the stomach, and restricting the amount of solid food that can be consumed. There are currently two brands of bands approved for use in the United States.

During the procedure, surgeons usually use laparoscopic techniques (using small incisions and long-shafted instruments), to implant an inflatable silicone band into the patient's abdomen. Like a wristwatch, the band is fastened around the upper stomach restricting the passage of food into the remainder of the stomach, and limiting a patient’s ability to eat large amounts quickly. This results in weight loss.

To modify the size of the band, its inner surface can be inflated or deflated with a saline solution. The band is connected by tubing to an access port, which is placed well below the skin during surgery. After the operation, the surgeon can control the amount of saline in the band by entering the port with a needle through the skin.
Risks Common to Gastric Bypass, Adjustable Gastric Banding, and Sleeve Gastrectomy

All operations entail some degree of risk. The risk of complication in any of the bariatric surgery cases is about 5%. Some complications may occur near the time of surgery, and others may develop years later. Certain risks are common to many operations, and other risks are unique to specific operations. While this is not an exhaustive list, risks that the gastric bypass procedure, adjustable gastric banding, and sleeve gastrectomy have in common include:

- Bleeding
- Infection
- Injury to other structures or organs, such as stomach, esophagus, spleen, liver or surrounding organs
- Conversion to open procedure
- Pneumonia
- Complications due to anesthesia and medications
- Deep vein thrombosis (clotting in the veins, commonly in the lower extremities or pelvis)
- Pulmonary embolism (blood clots in the large vessels leading to the lungs)
- Carbon dioxide embolism due to the gas used to inflate the abdomen for laparoscopy
- Dehiscence (separation of areas that are stitched or stapled together)
- Ulcers
- Stroke or heart attack
- Stenosis (narrowing of a passage)
- Vitamin or micronutrient deficiencies and associated problems
- Malnutrition
- Gall bladder disease
- Depression
- Death

This is not a cosmetic procedure or plastic surgery. The goal is improved quality of daily living, living healthier, living longer, resolution and/or improvement of medical problems, and cure or control of serious associated illness. The benefit of feeling good about yourself with improved confidence and self-esteem may occur, however, some patients experience social or emotional upheavals. Emotional crises such as divorce, acute job dissatisfaction, and other problems can occur as a result of all the changes that occur after the operation. Development of drug or alcohol addiction, probably as a result of replacing a preoperative food addiction, has also been reported.
Additional Risks of Gastric Bypass

Risks and complications during surgery may include perforation of the stomach or intestine, leak from the intestinal or stomach connections (anastomoses) with consequent peritonitis or abscess, internal bleeding, wound infection (necessitating opening of the wound), incisional hernia, internal hernia, injury to the spleen with potential removal of the spleen, and bowel obstruction.

Narrowing (stenosis) of the anastomosis (the outlet of the stomach), and/or ulcer can occur. Ulcers may be caused by smoking, overeating, aspirin, Goody’s, Stanback, or non-steroidal anti-inflammatory drugs (ibuprofen, naproxen, etc). Cortisone use in the postoperative period may also lead to a higher incidence of ulcers.

Other late problems include failure to lose adequate weight or weight regain. Dumping syndrome (fast heartbeat, nausea, vomiting, fainting, diarrhea in response to eating concentrated sweets) is often be described as a side effect of the operation.

Anemia may occur after gastric bypass. Close attention must be given to iron deficiency, especially in women of childbearing age. Taking a multivitamin with iron usually prevents this problem. Vitamin B12 supplements are also necessary to prevent anemia. Occasionally other vitamin or micronutrient deficiencies such as Vitamin D, or thiamine deficiency may occur, and, if severe, could cause serious harm to the patient.

Although rare, death may occur as a result of one of the complications of this operation. Previously the chance of death from gastric bypass surgery was estimated at 1%, or 1 in 100 patients. More recent data puts the risk of death from gastric bypass at 0.5% or about 1 in 200 patients.
Additional Risks of Adjustable Gastric Banding

The adjustable gastric band is a permanent implant. Risks unique to the gastric band include slippage (stomach is forced into the band perhaps with vomiting causing obstruction of the stomach), erosion of the band through the stomach wall, leakage leading to deflation, dilation of the esophagus, esophageal motility disorders, infection, or nausea and vomiting. In fact, several studies demonstrate a need for reoperation in up to 1/3 of patients with bands. Also, some research has revealed 20-30% of bands ultimately are removed for a variety of reasons.

Patients who become pregnant or severely ill, or who require more extensive nutrition may require deflation of their bands. On the other hand, band adjustments (fills) are meant to be permanent, and would only be drained or decreased if the patient is having problems related to the band being too tight. Bands are not loosened for a special occasion, then tightened again afterwards. Band adjustments may require out of pocket expenditure, and are not necessarily covered by insurance.

Patients should not expect to lose weight as fast as gastric bypass or sleeve gastrectomy patients, nor should they expect to lose as much weight as those patients. Band inflation should proceed in small increments. Anti-inflammatory agents, such as aspirin, should be used with caution and may contribute to an increased risk of band erosion.

Placement of a adjustable gastric band is major surgery and, like any surgery, death can occur. The risk of death from laparoscopic adjustable gastric banding is estimated at 0.1%, or about 1 in 1000 patients.
Additional Risks of Laparoscopic Sleeve Gastrectomy

While there is no anastomosis or connection made, the stomach is divided with a stapling device leaving a long staple line the length of the organ. That staple line could bleed, ulcerate, or leak. The sleeve gastrectomy achieves weight loss by restricting the size of the stomach, therefore it is necessary to make the sleeve of remaining stomach fairly narrow. However, that very reduction in diameter can result in stenosis or obstruction preventing the passage of food and causing intractable nausea and vomiting. That complication may require intravenous feeding, reoperation, or even conversion to a gastric bypass procedure ultimately.

There have also been reports of splenic vein thrombosis (clotting of the vein draining the spleen), and severe gastroesophageal reflux not responsive to medical treatment. It is the newest addition to the weight loss surgery armamentarium, therefore less is known about its long term implications, complications, or success rate compared with gastric bypass or adjustable gastric banding.

The risk of death from sleeve gastrectomy is estimated at about 0.4%, or 4 out of 1000.
Results of Weight Loss Surgery

Weight Loss

The amount of weight a patient will lose with each operation is variable, and somewhat unpredictable. Certainly, patients who diet, exercise regularly, and are compliant with recommendations tend to have superior results. However, the type of surgery also impacts the degree of weight loss. Success is often defined by the percent of excess weight a patient loses. For instance, if a patient is 120 lbs. overweight prior to the operation and loses 60 lbs., that represents a 50% excess weight loss, and 50% excess weight loss is considered success. With that in mind, gastric bypass patients lose an average of 60-80% of their excess weight, and have ~80% chance of success. Gastric banding patients lose an average of 25-55% of their excess weight and have only about 40% chance of success. Sleeve gastrectomy patients lose an average of 50-70% of their excess weight and have ~60-70% chance of success. Clearly, though, not everyone is successful with weight loss surgery, and some patients lose much less than those listed percentages. Rarely, patients may even lose too much weight.

Co-morbidities

Numerous studies have demonstrated improvement in conditions such as hypertension, diabetes, lipid disorders, obstructive sleep apnea, and arthritis with weight loss. Each of the operations result in varying degrees of improvement in these co-morbidities. In general, gastric bypass surgery tends to produce the most improvement, with sleeve gastrectomy producing marginally less improvement, and adjustable gastric banding producing the least improvement. Long term data with large numbers of patients undergoing sleeve gastrectomy is lacking, however, so the durability of these improvements with sleeve gastrectomy is unknown. Not everyone who undergoes bariatric surgery will see improvement in these or other health conditions.

The Postoperative Period

The typical hospital stay is 1-2 nights for laparoscopic gastric bypass, one night or less with adjustable gastric banding, and 1-2 nights for sleeve gastrectomy patients. Patients are asked to be up and walking by the evening of their operation. Postoperative recovery is similar among the three operations. Most patients are able to return to work within 2 weeks of the surgery, but the amount of time required varies with the individual and the type of work they do.

Medication is best taken as a chewable, crushed, dissolved, or liquid form if available as such. However, not all medications can be prescribed in those manners, and most gastric bypass and sleeve gastrectomy patients are able to swallow pills if necessary.
Adjustable gastric band patients may have more difficulty. You should discuss medication alternatives with your treating physician(s) as we cannot manage those.

Diet progression varies with each operation, but generally follows the following pattern.

<table>
<thead>
<tr>
<th>Time after surgery</th>
<th>Gastric Bypass</th>
<th>Gastric Banding</th>
<th>Sleeve Gastrectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day of surgery</td>
<td>nothing</td>
<td>liquids</td>
<td>nothing</td>
</tr>
<tr>
<td>1st day</td>
<td>liquids</td>
<td>liquids</td>
<td>liquids</td>
</tr>
<tr>
<td>2nd day</td>
<td>soft / pureed</td>
<td>liquids</td>
<td>liquids</td>
</tr>
<tr>
<td>0-2 weeks</td>
<td>soft / pureed</td>
<td>liquids</td>
<td>liquids</td>
</tr>
<tr>
<td>2-4 weeks</td>
<td>soft chewable</td>
<td>pureed</td>
<td>pureed</td>
</tr>
<tr>
<td>4-6 weeks</td>
<td>regular</td>
<td>soft chewable</td>
<td>soft chewable</td>
</tr>
<tr>
<td>&gt;6 weeks</td>
<td>regular</td>
<td>regular</td>
<td>regular</td>
</tr>
</tbody>
</table>

Long term diet is similar among the operations. We recommend avoidance of liquid calories such as soda and fruit juices. Remember, surgery does not relieve you of the responsibility to diet, it simply helps you to do so. But you are ultimately responsible for what you eat, the calories you consume, whether or not you exercise, and the weight you lose. **Long term follow-up, not just a year or two, is mandatory.** Surgery is part of a larger lifestyle change, and the pounds do not melt away without any effort on your part.
Bariatric Surgery Quiz

*Please take this self-quiz before you make any further steps toward surgery. Understanding what will happen after surgery and what you must do to be successful is the most important step of the process. Please ask us if you have any doubts or questions about any of these or other issues. Return this quiz with your forms.*

<table>
<thead>
<tr>
<th></th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The gastric bypass stomach is designed to hold &lt;1 ounce.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>All gastric bypass operations are laparoscopic, never as open procedures.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sleeve gastrectomy involves removal of about 30% of the stomach, leaving most of it intact.</td>
<td></td>
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<tr>
<td>4</td>
<td>The risk of complication from gastric bypass or band surgery is about 5%.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Some risks or complications of these procedures may not present until long after the operation.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The risk of death from gastric bypass surgery is about 1 in 200 or 0.5%.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Ulcer and narrowing of the anastomosis are potential problems of gastric bypass surgery.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Erosion and/or slippage never occur in adjustable gastric band cases.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The risk of death from sleeve gastrectomy is about 4 in 1000, or 0.4%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Leaks of the staple line and narrowing (stenosis) of the sleeve are never problems with sleeve gastrectomy.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The risk of death from adjustable gastric banding is about 1 in 1000, or about 0.1%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>After surgery, I will be able to eat anything I want and as much as I want.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Diabetes, high blood pressure, back pain and similar ailments <strong>always</strong> get better after obesity surgery.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>It is possible that I will have more emotional difficulties after surgery because of the many changes my body and my relationships will go through.</td>
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<td></td>
<td></td>
<td>TRUE</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>15</td>
<td>Re-operation is necessary in up to 1/3 of band patients</td>
<td></td>
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<tr>
<td>16</td>
<td>If I get the Lap-Band procedure, I can have an adjustment to have the band opened more to eat more for a special occasion, like a wedding.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>This operation for obesity will only require routine visits with my surgeon for the first year, and then I will be okay on my own and not have to come back.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Having bariatric surgery will melt the pounds off me without lifestyle changes of diet and exercise, since those things have not helped in the past.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>There are complications and risks that I should discuss with the surgical team, and weight loss and surgical outcomes are not guaranteed.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Band adjustments may require out of pocket costs because insurance does not always cover them.</td>
<td></td>
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</tbody>
</table>

Patient Name: ____________________________________________

Date: ___________
## DIET HISTORY FORM

Name: ______________________________________________________________

How long have you struggled with your weight? ____________________________

<table>
<thead>
<tr>
<th>Type of Weight Loss Program</th>
<th>Number of Times Tried?</th>
<th>How long did you follow the Diet?</th>
<th>What year(s) did you try the diet?</th>
<th>What were the results (long-term and short-term?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Watchers</td>
<td></td>
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</tr>
<tr>
<td>Physician Supervised Diets</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TOPS</td>
<td></td>
<td></td>
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<tr>
<td>Overeaters Anonymous</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Prescription Diet Pills</td>
<td></td>
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<tr>
<td>Behavior Modification</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Psychotherapy (group or individual)</td>
<td></td>
<td></td>
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<tr>
<td>Unsupervised Diets (Slim Fast, Calorie Counting, etc.)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Comments:______________________________________________________________________
_______________________________________________________________________________

Signature: _____________________________________ Date: ______________________
DEPARTMENT OF SURGERY
NEW PATIENT INFORMATION

Date of visit: ________________ Date of Birth: ________________ Age: _____________
Referring Doctor: ____________ Reason for visit: __________________________________
Physician Notes: ________________________________________________________________
__________________________________________________________________
__________________________________________________________________

PAST MEDICAL HISTORY
☐ High Blood Pressure ☐ Lung Disease ☐ Asthma ☐ Diabetes ☐ Seizure
☐ Kidney/Bladder Disease ☐ Thyroid Disease ☐ Stroke ☐ Hepatitis ☐ HIV/AIDS
☐ Heart disease ☐ Blood Transfusion ☐ Cancer of________________________________
☐ Other ________________________________________________________________

PAST SURGICAL HISTORY (Include year of the procedure)
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

CURRENT MEDICATIONS   DRUG ALLERGIES
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

BLEEDING HISTORY (Please √ all that apply)
☐ Excessive bleeding ☐ Easy bruising ☐ Aspirin use ☐ Coumadin use
☐ Other ________________________________________________________________

FAMILY HISTORY (Please √ each item that has occurred in your parents, children, brothers,
sisters, grandparents, uncles, and aunts)
☐ High Blood Pressure ☐ Liver Disease ☐ Heart Disease ☐ Ulcers
☐ Diabetes ☐ Thyroid Disease ☐ Kidney Disease ☐ Cancer
☐ Other ________________________________________________________________

SOCIAL HISTORY (Please √ all that apply)
☐ Smoke __________ packs per day for _____________ years
☐ Alcohol ________________ use for _____________ years
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Children (Ages): _________________________ Occupation: _________________________
REVIEW OF SYSTEMS (Please √ all that apply)

Constitution: □ Weight loss □ Weight gain □ Night sweats □ Fevers
Skin: □ Change in size/color of moles □ Rash □ Bruising
Eyes: □ Poor vision □ Double vision □ Blurred vision □ Glasses
ENMT: □ Pain □ Deafness □ Discharge □ Ringing in ears □ Hoarseness
□ Sinus drainage □ Nose bleed
Cardiac: □ Palpitations □ Chest pain □ Shortness of breath □ Fatigue
□ Swelling in feet/legs
Respiratory: □ Cough □ Production of sputum □ Coughing of blood □ Pain
Gastro: □ Painful swallowing □ Nausea □ Vomiting □ Vomiting blood
□ Indigestion □ Diarrhea □ Constipation □ Tarry stools
□ Yellow jaundice □ Bloody stools □ Change in BMs
Genito: □ Kidney/bladder disease □ Decreased urine stream
□ Unable to urinate □ Painful urination □ Blood in urine
Musc/Skel: □ Weakness □ Trauma □ Limited motion
□ Bone/joint deformity
Neuro: □ Paralysis □ Weakness □ Seizure □ Fainting □ Headache
□ Migraine □ Incoordination □ Head trauma
□ Numbness/tingling in extremities
Psych: □ Anxiety □ Depression □ Hallucinations
Endocrine: □ Change of appetite □ Excessive thirst/urination □ Goiter
Hemato: □ Swollen lymph nodes □ Bleeding disorders
Immu: □ Immune disorders □ Immunosuppression

**Females only**
Breast: □ Lumps □ Pain □ Nipple discharge □ Infection □ Trauma
□ Last mammogram (date) ________________
Gyn: □ Irregular periods □ Hormone therapy □ Menopause
□ Last pelvic exam (date) ____________ □ Last period (Date) ____________

Signature: __________________________   Date: _____________________
Blood Product Release

The practice of surgery is an invasive art with inherent risks. One of the risks of performing bariatric surgery, laparoscopic or open, is the risk of bleeding. We use all means available to minimize this risk and rarely are blood or blood products necessary. The use of blood products, when needed, however, can be life saving.

Some patients have personal or religious reasons for refusal of blood transfusions, choosing instead death over the use of blood products, even if medically necessary. While we respect those personal beliefs, we do not feel we could allow a patient to die from an elective operation when a blood transfusion might save the patient’s life. Therefore, we cannot guarantee against the use of blood or blood products during or after gastric bypass, sleeve gastrectomy, or laparoscopic adjustable gastric banding. If you desire to continue pursuing bariatric surgery at UAB, you acknowledge and consent to an elective bariatric surgical procedure from a surgeon who will use life saving measures, including blood transfusions, if it is deemed necessary by the surgeon to save your life. If you are unwilling to receive blood or blood products as deemed necessary by your surgeon, we respectfully request you seek the care of a different bariatric surgery program.

I have read this form, and acknowledge by signing it I am agreeing to receive blood and/or blood products at the discretion of my surgeon or other physicians involved in my care, should that be deemed necessary at the time of my surgery.

____________________________________________
Signature of Patient or Authorized Parent or Guardian

Date Signed:______________________
# DEMOGRAPHIC FORM

**PLEASE COMPLETE FORM AND FAX TO: 205-975-4182**

**New Patient Information Form**

Jayleen Grams, M.D. or Richard Stahl, M.D. 
Attn: Marci P. Howard 
1720 2RD Avenue So, KB 429 
BIRMINGHAM, AL 35294-0016 
Phone: 205-996-5182  Fax: 205-975-4182  

**PLEASE FILL OUT COMPLETELY AND ACCURATELY**

<table>
<thead>
<tr>
<th><strong>Patient Information:</strong></th>
<th><strong>Email:</strong></th>
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<tr>
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<td>Height:</td>
<td>Weight:</td>
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<tr>
<td>Select one: Gastric Bypass</td>
<td>Lap Band</td>
<td>Sleeve</td>
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Name: _______________________________________________________________________
Address: ____________________________________________________________________
City/State: ___________________________________________ Zip: ______________________
Soc. Sec. No: _____________________ Sex: _____ DOB: ____________ Age: __________
Home Phone: (____)__________________ Cell: (____)_________________
Marital Status: M D S W Religion: _________________ Race: B W A O
Employer: __________________________ Work Phone: (____)______________
Emergency Contact: ___________________________ Phone: (___)_________________

**REFERRING PHYSICIAN:**

NAME __________________________________________________________
ADDRESS _____________________________ CITY/STATE _______________ ZIP __________
PHONE ____________________ CONTACT ___________________________

**PRIMARY PHYSICIAN:**  NAME___________________________________________
PHONE ____________________________

**Insurance Information:**
(Please include a copy of insurance card, front and back)

Insurance: ____________________ Subscriber Name: ____________________
Policy No: ____________________ Verification Phone No: (____)_____________
Group No: ____________________ Effective Date: ______________ Copay: ________
### Body Mass Index Table

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight. The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.

<table>
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</tbody>
</table>

Body Mass Index Table adapted from the National Heart, Blood and Lung Institute, available at: [www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl2.htm](http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl2.htm)  Accessed August 4, 2010
Medical Weight Loss Progress Note

Documentation must be present of participation in a physician-supervised program of nutrition and increased physical activity (including low calorie diet, increased physical activity and behavioral modification). Documentation of program participation must appear in the medical record by the attending physician. Documentation should include comments by the physician regarding patient progress or lack of progress. A letter does not meet this requirement. There must be medical records to document medically supervised weight loss attempts.

Name_________________________ Date_____________________

Weight________________________ Blood Pressure____________

Pounds Lost/Gained______________ BMI____________________

Diet Plan

Include notes from Diet Plan with PCP notes

☐ Weight Watchers ☐ LA Weight Loss ☐ Jenny Craig ☐ EatRight

Weight loss medications: ________________________________

Daily calorie intake: 1000 cal 1200 cal 1500 cal

Physical Activity / Exercise Plan

List number of times per week each activity is attempted in the box provided

☐ Gym ☐ Walking ☐ Aerobics ☐ Swimming ☐

Unable to exercise for medical reason (joint pain, chest pain, etc.) Please list reason:

____________________________________________________

Behavior Modification

(Lifestyle changes) to include discussions of proper eating habits, healthful snacking, etc.

Please indicate items discussed:

☐ Discussed dietary intake and gave suggestions

☐ Discussed exercise routine and gave suggestions

☐ Discussed psychological changes and gave suggestions

Assessment/Suggestions:__________________________________________

_____________________________________________________________

_____________________________________________________________

MD Signature_________________________________________________
# UAB Fresh Beginnings Support Group Birmingham

**UAB Hospital Bariatric Support Group 2015 Schedule**

All “Fresh Beginnings” meetings at UAB Hospital will be held in the West Pavilion Conference Center Room E, unless listed on the schedule.

NO MEETINGS MAY and DECEMBER 2015 in Birmingham.

Please consider the weather before traveling to a meeting.

There will be a $10 fee per meeting payable to UAB Hospital for patients who are not going through or have gone through the program at UAB Hospital.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Speaker</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 26</td>
<td>6:00pm</td>
<td>Dr. Taranéh Soleymani</td>
<td>UAB Medical and Surgery Weight loss Program</td>
</tr>
<tr>
<td>February 23</td>
<td>6:00PM</td>
<td>Jennifer Roberson, RN, MSN</td>
<td>Nursing Care of the Weight loss Surgery Patient</td>
</tr>
<tr>
<td>March 30</td>
<td>6:00pm</td>
<td>Lakeyra McCoy, Pharm. D.</td>
<td>Medications After Surgery</td>
</tr>
<tr>
<td>April 28</td>
<td>6:00PM</td>
<td>Patients</td>
<td>Look at us Now!</td>
</tr>
<tr>
<td>May 2015</td>
<td>NO MEETING!</td>
<td></td>
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</tr>
<tr>
<td>June 29</td>
<td>6:00PM</td>
<td>Dr. Jaylen Grams</td>
<td>A Word from the Doc!</td>
</tr>
<tr>
<td>July 27</td>
<td>6:00PM</td>
<td>Phyllis Gaines, RN</td>
<td>“Comparison of Procedures”</td>
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<tr>
<td>Date</td>
<td>Time</td>
<td>Speaker Name</td>
<td>Title</td>
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<tr>
<td>August 25, 2015</td>
<td>6:00PM</td>
<td>Round Table Discussion</td>
<td>Bariatric Surgery Issues</td>
</tr>
<tr>
<td>September 28, 2015</td>
<td>6:00PM</td>
<td>Marci Howard, Patient Services Coordinator</td>
<td>A Word From Your Insurance Company</td>
</tr>
<tr>
<td>October 27, 2015</td>
<td>6:00PM</td>
<td>Judy Walthaw, Dietician</td>
<td>Holiday Eating or What Not to Eat</td>
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<tr>
<td>November 24, 2015</td>
<td>6:00PM</td>
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<td>Fashion, Award and Benefit Event</td>
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</table>

(Please call if you would like to participate by modeling and share your successes)

At each meeting we will have an exercise tip for the month presented by Brian King, PT
Physical Therapy Department UAB Hospital
For information on Pool Program and Post Surgical Exercise call 205 934 1163.

We always meet the last Monday of the month, except May and December.
You are welcome to bring friends, family or co-workers to the meetings.
We ask that everyone sign in when attending the meetings.
UAB Hospital has retained “full approval” of reaccreditation and will remain officially recognized as an “American College of Surgeons Level 1 Bariatric Center of Excellence”, as of December 8, 2012.
UAB Support Group-Montgomery Alabama
You are invited to attend the UAB Fresh Beginnings support group in Montgomery, Alabama the third Thursday of every other month at 6 PM.

Baptist Hospital South
Montgomery Cardiovascular Institute
2119 East South Blvd
Montgomery Alabama 36116
Auditorium in the Basement
Jackie Byrd 334-551-2010
jbyrd@uabmontgomery.com

We invite all of our patients in this area to attend. We have more than 400 patients in this area. Remember your commitments when you began the process to have your weight loss surgery (WLS), life style changes, keeping your follow up doctors’ appointments and joining a support group, just to name a few. Are you keeping your commitments? We pledge to keep ours!

We want to make sure that you receive credit for attending the support group meetings, so please be sure to sign in when you attend. The sign in sheet is your proof that you attended the meetings. Please print legible and include your email address.

THERE WILL NOT BE A MONTGOMERY MEETING IN January, March, May, July, September, or November 2015!
You are welcome to attend the other scheduled meetings.
Please check the weather forecast before traveling to the meetings. If the weather is inclement, we will cancel the meeting. Your safety is important to us! Please call 205 996 6984, if you have questions.

Baptist Hospital Map Attached.
Meeting in Auditorium in the Basement
Agenda Fresh Beginnings Support Group Montgomery, Alabama
Speakers may change without prior notice!

January 2015  NO MEETING

February 19, 2015 6 PM
Speaker: Jackie Byrd
Administrative Assistant
University of Alabama Montgomery
Topic: Round Table Discussion

March 2015  No Meeting

April 16, 2015 6 PM
Speaker: Deborah Thedford-Zimmerman RN
Bariatric Surgery Coordinator UAB Hospital
Topic: Vitamins and Supplements

May 2015 No Meeting

JUNE 18, 2015 6 PM
Speaker: Round Table
Topic: Meal Planning
(Each person is to bring a healthy recipe used in meal planning. Please bring a few copies to share with the members. Tell us your secrets for meal planning and healthy eating).

July, 2015  No Meeting

August 21, 2015 6 PM
Speaker: Panel Discussion
Montgomery Group Members
Topic: Our Journey
September 2015 No Meeting

October 16, 2015 6 PM
Speaker: Jackie Byrd
Panel Discussion
Topic: Holiday Eating

NO MEETING in NOVEMBER 2015
Happy Thanksgiving!

December 18, 2015 6 PM
Holiday Celebration/ Pot Luck/Appreciation
Picture Sharing
Success!

UAB Montgomery Bariatric Support Group
Baptist Hospital South
Jackie Byrd 334-551-2010
Or contact
Deborah Thedford
dthedfor@uabmc.edu
205-996-69984

Please check the weather report for inclement weather watches!!!
Please call the office if questions about meeting dates and cancellations

Please make sure we have your email address for faster information!

UAB Medicine
Knowledge that will change your world
www.uab.edu/bariatrics
Directions and parking to UAB Highlands

Location:
1201 11th Avenue South
Birmingham, AL 35205

Main number for UAB Highlands (205) 930-7000

I-65 Southbound - Take exit 259-B (4th Avenue South), exit to the right and loop back under I-65. At the second stop light, turn right onto 13th Street South. (There will be an Amoco at the intersection). Stay on 13th Street South until you come to UAB Highlands.

I-65 Northbound – Take exit 259 (8th Avenue South), turn right onto University Boulevard. At the third stop light, turn right onto 13th Street South. Stay on 13th Street South until you come to UAB Highlands.

Red Mountain Expressway (Highway 31/280) - Take the 8th Avenue South exit, go west on University Boulevard (toward town). Travel through the UAB campus, turn left at 13th Street South (landmark: UAB arched overpass). Stay on 13th Street South until you come to UAB Highlands.

From The Kirklin Clinic® – Turn right onto 5th Avenue South, then immediately turn right onto 22nd Street and turn right again onto 6th Avenue South. Stay on 6th Avenue South until you come to 13th Street South. Turn left on 13th Street South and proceed to UAB Highlands.

Medical Center - Turn south onto 6th Avenue South (landmark: UAB arched overpass). Continue two blocks to find convenient parking at UAB Highlands.
Where do I park for UAB Weight Loss Medicine?
UAB Weight Loss Medicine is conveniently located at UAB Hospital-Highlands at the address below. Free parking is available on a fenced, one-level lot next to the hospital building and in a parking deck located on 12th Street next to The Pita Stop restaurant.

UAB Hospital-Highlands, Suite 515
1201 11th Avenue South
Birmingham, Alabama 35205

(205) 934-7053
Main number for UAB Highlands (205) 930-7000
Approximate Weight Loss Surgery Private Pay Fees

In the event that your insurance does not approve you to have the operation or does not pay for these procedures:

*Initial Consultation:* Approximately $439.00 (Cost incurred for Pre-op Assessment Appointment prior to surgery not included)

*Blood Work:* $400-$600

*Psychological Evaluation:* Depends on each individual’s insurance coverage. Patient must call insurance company to determine fees.

*Nutritional Evaluation:* $50

*Laparoscopic Adjustable Gastric Banding, Sleeve Gastrectomy, or Gastric Bypass Fees:* $20,500