Bariatric Pre-Surgical Psychological Evaluation

Richard L. Azrin, Ph.D. - Cheryl Millsaps Ph.D.
Birmingham Neuropsychology, LLC
2018 Brookwood Medical Center Drive,
Professional Office Building – Suite 310
Birmingham, AL 35209
Phone: 205.329.7815 Fax: 205.329.7816

Doctor / Other _____has referred patient: _____for an evaluation

On Appointment Date: _____Time: _____

Please fill out the **Bariatric Pre-Surgical Psychological Evaluation Form** before the appointment and bring that form to the appointment, along with your glasses (if needed) for reading and a sweater if you are prone to be cold.

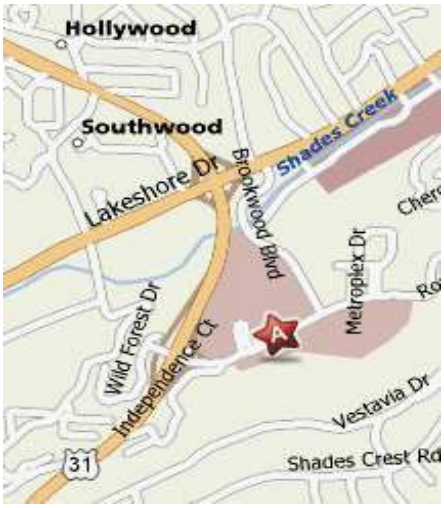
The evaluation usually lasts from **3 to 5 hours**, depending on each patient. A good night's sleep and breakfast are recommended. If you have difficulty reading or writing, please inform our office prior to the appointment so that accommodations may be made. Some psychological test will usually be given before meeting with the doctor. The doctor will then spend time with the patient to get a history and review test results.

Pre-surgical assessments are commonly requested for individuals who are about to undergo gastric bypass surgery. Your assessment will be conducted by Dr. Richard L. Azrin or Dr. Cheryl Millsaps, Licensed Psychologists. The doctors will be assessing personality using a wide range of tests by asking patients to answer questions and complete questionnaires. The assessment does not involve a medical check-up.

The evaluation is painless and may provide interesting information regarding a person's personality. Thank you for your time and effort.

If you have any questions, please call (205) 329 7815

Directions: **Coming from I-59 toward Birmingham**, merge onto US-31 South via exit number 126A. Take the Brookwood Medical Center Drive exit and follow directions to parking. **Coming form I-65 toward Birmingham**, merge onto I-59/I-20. Merge onto US-31 and take Brookwood Medical Center Drive Exit. **Coming from I-459**, merge onto US-31 via exit 13. Take the Brookwood Medical Center Drive exit. **Coming from Hwy 31**, take the Brookwood Medical Center Drive exit located between Vestavia and Homewood. **Coming from Lakeshore Parkway**, go under Hwy 31 overpass, turn between the Shell gas station and the Compass Bank and follow the signs to parking. **Parking** is in **Blue** area of the professional building parking deck. Our office is in the Professional Office Building (abbreviated **POB**) of Brookwood Hospital. When you park in the blue area, the walkway will take you to the POB 2nd floor, take elevator to the 3rd floor then go to your left to **Suite 310**.



Bariatric Pre-Surgical Evaluation Form
CONFIDENTIAL

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Voice: (205) 329-7815 Fax: (205) 329-7816

Instructions: Please complete this form as accurately/completely as you can.
A doctor will discuss your responses with you during your appointment.

Patient's Name: Mr /Ms /Mrs _____Evaluation Date:___/____/____

Your Home Address: _____Zip: _____

Home Phone: _____ Work/Other Phone:_____ Soc Sec Num: _____

Date of Birth: _____/_____/_____ Age: _____ Race: _____ Gender (circle): Male Female

Marital Status (circle) Single / Married / Divorced / Separated / Widow

Which surgeon (or doctor) referred you to this clinic?: Dr. _____

Besides referral source, do any other doctors need a copy of your report? _____

Which surgery are you interested in having? (circle) Gastric Bypass/ Lap band / Realize Band / gastric sleeve / other: _____

Weight Loss History / Surgery Knowledge I_____ O_____ L_____ G:_____

What is your approximate current weight? _____ Height? _____Your Goal Weight after surgery? _____

How long have you been considering surgery? _____

When was your first appointment with the surgeon? _____

What / who made you interested in the surgery? _____

What are your reasons for wanting the surgery? _____

_____

Have you attended any Surgical Seminars? (circle) Yes No If Yes, # attended _____

Have you attended any Surgical Support Groups? (circle) Yes No If Yes, # attended _____

Do you feel you adequately understand the surgical procedure? (circle) Yes No If No, Questions: _____

_____

Do you feel you adequately understand the lifestyle changes required after surgery? (circle) Yes No

If No, Questions: _____

How do your family / friends feel about you having the surgery? _____

_____

Have you ever taken laxatives or vomited on purpose because you ate too much food? No Yes

How much and how often do you exercise? _____

_____

Exercise limitations (describe): _____

_____

Notes / Comments: _____

_____

_____

Medical History (Please circle all that apply)

Joint Pain Short of Breath High Blood Pressure High Cholesterol Sleep Apnea Arthritis Diabetes

Heart Disease Stroke Cancer Head Injury Emphysema COPD Asthma Incontinence Thyroid

Pain in: back hips knees feet other _____ Swelling (where) _____

Past Surgeries: back knee gallbladder hysterectomy Other: _____

_____

Other medical illnesses: _____

_____

Significant Symptoms:

Please indicate whether you have experienced any of the symptoms below, when, and briefly describe:

Symptom	Circle Yes or No		When it began	Please briefly describe problem(s) and treatments, if any
Loss of Consciousness	No	Yes		
Memory Difficulties	No	Yes		
Blurred/Double Vision	No	Yes		
Muscle Jerks or Twitches	No	Yes		
Bowel or Bladder Problems	No	Yes		
Speech Difficulties	No	Yes		
Sleep Difficulties	No	Yes		
Decreased Energy	No	Yes		
Decreased Motivation	No	Yes		
Decreased Happiness	No	Yes		
Social Isolation	No	Yes		
Frequent Headaches	No	Yes		
Dizziness	No	Yes		
History of Anorexia	No	Yes		
Bulimia/vomiting/laxative	No	Yes		
Seizures	No	Yes		
Frequent Anxiety	No	Yes		
Persistently Depressed Mood	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Mental Confusion	No	Yes		
Driving Difficulties	No	Yes		
Excessive Worry	No	Yes		
Unusual/Frightening	No	Yes		
Other				

_____

_____

Current Medications:

Name of Medicine	What is it for?	Name of Medicine	What is it for?

Please tell us about any Family History of Medical or Psychiatric Illness (circle all that apply):

Diabetes High Blood Pressure Heart problem Obesity Stroke Cancer Alcoholism Drug abuse

Other (list) _____
Family history of **Psychiatric Illness** (list) _____

_____

Your Psychiatric/Psychological History

Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling, psychological counseling, medicines for depression or anxiety, etc): (circle) **Yes** **No** If yes, please describe below:

Problem	Date (From – To)	Describe Treatment received

Have you ever considered or attempted suicide? No Yes (describe) _____

_____

Have you ever heard or seen things that others didn't (hallucinations)? No Yes (describe) _____

_____

Substance Use

Are you currently drinking? No Yes Total number of years drinking on a fairly regular basis: _____

Average amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc) _____

What type of alcohol do you typically drink? (12 oz. can of beer, 6 oz cup of wine, shot of hard liquor) _____

Have you ever been addicted to any drugs? No Yes (describe) _____

_____

Have you ever failed at attempts to quit alcohol or drugs? No Yes (describe) _____

_____

Have people ever said you should quit drinking or using drugs? No Yes (describe) _____

_____

Have alcohol or drugs ever caused social or job problems? No Yes (describe) _____

_____

Have you been involved in any treatment for drinking alcohol (including A.A.) or Using drugs? No Yes

Cigarette Smoking:

Are you currently smoking? No Yes If you smoked previously, when did you stop? _____

Briefly describe attempts to quit smoking: _____

Approximately how many years smoked in lifetime: _____Average number of packs/day: _____

Educational/Occupational History:

Education: High school degree? Yes No or Years of college _____ Other _____

Occupation: _____ Currently working? No Yes, Where? _____

_____

Social History How many kids do you have?____ **Who lives in your household? (Fill in any living at home below):**

Spouse (# years married: _____) Children (# _____) and ages: _____Parents Other: _____

Relationship problems: _____

Do you have someone who can take care of you after you are released from the hospital? Yes No

Name: _____Relation: _____

New Patient Information

Patient Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Sex: **M F** Patient's Employer_____

Birth Date _____ Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Marital Status: _____ Driver License #: _____

Spouse/Partner Name _____ Spouse Soc Sec #:_____

Spouse place of Employment _____ Spouse Phone #: _____

Other Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone (____)_____

Insurance Information

1) Name of **Primary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

2) Name of **Secondary** Insurance: _____

Contract #_____ Group #_____Effective Date_____

Policy Holder's Name: _____ DOB_____ Soc Sec Number _____

Relationship_____ Employer_____ Phone #'s: _____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waive all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 201 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form. Informed Consent**: I agree to participate in evaluation/treatme and the purpose has been explained to me and/or my guardian/representative.**

Signature of Patient or Responsible Party: _____ Date_____

If signed by a responsible party, describe that representative's authority to act for the patient_____

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Patient Name: _____ Date of Birth: _____

Social Sec. #_____ Date(s) of requested records: _____

I hereby authorize the above providers to obtain and release the protected information specified below.
Please list any restrictions on this release of information_____

Name_____ Phone_____ Fax_____
Address_____
City State Zip
Name_____ Phone_____ Fax_____
Address_____
City State Zip
Name_____ Phone_____ Fax_____
Address_____
City State Zip
Name_____ Phone_____ Fax_____
Address_____
City State Zip
Name_____ Phone_____ Fax_____
Address_____
City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctors last progress notes.
Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Margaret Smith, LCSW, Dr. Stuart Tieszen, Dr. Elena Herndon, Dr. Joel Melvin, Jeannie Briscoe, LCSW and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals.
I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist, psychiatrist, or social worker generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

Informed Consent**: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.**

_____ _____ _____
Name of patient and/or responsible party Signature of patient or responsible party Date

_____
If signed by patient's representative, a description of representative's authority to act for the patient is provided above.

*** Please fax records to Fax# (205) 329-7816 OR call Voice # (205) 329-7815