SSMHealth

In partnership with the Felician Sisters

Weight Management Services

SSMHealthIllinois.com/weight-management

Weight-loss Surgery *Packet*

Welcome Letter

Welcome to SSM Health Weight Management Services at St. Mary's Hospital in Centralia, IL. We are pleased you have expressed interest in our weight-loss program and that you have chosen us to assist you in your journey. We hope that you will find the information provided to you within this packet helpful in making this very important decision.

If you are interested in pursuing weight-loss surgery options, the paperwork needed to begin the process is included. Once completed, the paperwork can either be scanned and emailed back to us at **SSMHealthWMS@ssmhc.com** or faxed to **618-436-6105** Attention: Weight Management.

Your timely completion of these items will expedite the process of getting started with our program. Once the paperwork is completed and returned to our office, your information will be processed and you will be contacted with next steps. If you have any questions while completing this paperwork, please do not hesitate to call us at **618-436-8300**.

Obesity is a very serious and common health problem. Two-thirds of Americans are either overweight or obese, and it is estimated that more than 400,000 premature deaths every year can be associated with obesity. A BMI of 40, or 35 with significant associated conditions constitutes the definition of severe obesity.

It has been proven that bariatric surgery which provides significant weight loss, can in fact improve one's current health status and aide in the prevention of obesity related medical conditions. Bariatric surgery can provide you a powerful tool for your weight-loss journey, but is only one piece of the weight-loss puzzle. A patient will be required to follow a healthy diet plan, exercise regimen, vitamin and mineral supplementation and follow life-long rules required for a successful journey.

SSM Health Weight Management Services works with patients to provide a holistic approach in the treatment and management throughout our program. We will assist you in making the necessary behavioral changes and in the management of any physical or emotional issues associated with your weight. The decision to undergo weight-loss surgery is not one that should be entered into lightly. One must carefully weigh the potential risks involved and the anticipated benefits. These potential risks will be reviewed with each individual patient based upon their needs by your surgeon and the Weight Management Services team.

Thank you for allowing us the opportunity to accompany you on a new journey: One that will be successful in conquering your long-time battle with obesity.

Sincerely,

Deepu Sudhakaran, MD
SSM Health Weight Management Services

SSMHealth
In partnership with the Felician Sisters
Weight Management Services

Paperwork required for your first office visit

All of the information listed below is required at your first office visit.

Please use this as a check list to make sure you have everything that is required.

BE AWARE that if you do not bring the necessary completed information your first office visit **WILL BE RESCHEDULED. NO EXCEPTIONS.**

Checklist

- ❑ **Medical History/Sleep History/Diet and Nutrition History Questionnaire** – Must be filled out as completely as possible including dates and weight loss/gained.
- ❑ **Patient Information Sheet**
- ❑ **Primary Care Physician Referral Form** – Have this form completed by your doctor, with the doctor's signature, address and phone number completed.
- ❑ **Pre-Operative Immunization Waiver Form**
- ❑ **Insurance Review Form and Insurance Cards** – We will be taking a copy of the front and back of each card for proper billing to your insurance company at the time of your visit.
- ❑ **Notice of Privacy Practices**
- ❑ In addition to the completed information, you will be required to bring with you:
  - ❑ A photo ID
  - ❑ Your current insurance card(s)
  - ❑ A referral from your primary care physician
  - ❑ Your office copay

  It is also recommended that you bring your support person to the first appointment

1. You **MUST** bring your entire completed packet to your first office visit. If you fax or mail any paperwork to the office, bring a copy of the completed packet with you to the first appointment.
2. If you have any questions regarding any of the forms, please call to ensure that all information is complete at the time of the appointment.

Please note: We have included the Psychological Assessment information for your review. While this assessment **does not** need to be completed prior to your first visit, it is recommended that you schedule this appointment early in the process.

Thank you for your cooperation in this process.

Patient Information

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Patient Information		
Date form completed:		
Patient Name:	DOB:	Gender: ❑ Male ❑ Female
Height:	BMI:	Age:
Address:		
Best Contact Number: ❑ home ❑ cell ❑ work ❑ other		
Alternate Contact Number: ❑ home ❑ cell ❑ work ❑ other		
Email Address:	May we send you program information: ❑ Yes ❑ No	
Primary Language:	Interpreter needed: ❑ Yes ❑ No	
Education (last grade or degree completed):	Do you live alone?: ❑ Yes ❑ No	

Emergency Contact	
Name:	Relationship:
Address:	
Contact #: ❑ home ❑ cell ❑ work ❑ other	
Name:	Relationship:
Address:	
Contact #: ❑ home ❑ cell ❑ work ❑ other	

Pharmacy Information	
Preferred Pharmacy:	Phone Number:
Pharmacy Address:	

Patient Information

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Patient Information

Insurance Information

Primary Insurance Company:	Phone Number:
Subscriber Name:	
Subscriber Number:	Group Number:
Secondary Insurance Company:	Phone Number:
Subscriber Name:	
Subscriber Number:	Group Number:
Additional Insurance Company:	Phone Number:
Subscriber Name:	
Subscriber Number:	Group Number:

Healthcare Provider Information

Primary Care Physician:	
Clinic Address:	
Phone Number:	Fax Number:
Cardiologist/Heart Physician:	
Clinic Address:	
Phone Number:	Fax Number:
Other Healthcare Provider:	
Clinic Address:	
Phone Number:	Fax Number:
Other Healthcare Provider:	
Clinic Address:	
Phone Number:	Fax Number:

Insurance Review Form

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

This form is to help you determine whether or not your insurance policy has benefits for weight-loss surgery.

Please follow the instructions below.

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided should be read word-for-word to the customer representative to ensure the most accurate information possible.
4. Do not leave any fields blank.
5. Sign the form on the next page. Failure to do so will result in the form being returned.
6. Once complete, bring this form, along with a copy of your insurance card(s), to your first visit in our office.
7. If you have more than one insurance provider, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.

Insurance Review Form

Fill in this information before you call the insurance company.

Patient Name:	
Patient Date of Birth:	
Insurance Name:	
ID Number:	
Group Number:	
Subscriber Name:	
Subscriber Employer:	
Subscriber Date of Birth:	

Number	Question for Representative	Answer from Representative
1	Please look in my current certificate of coverage. Do I have benefits for weight-loss surgery for morbid obesity if medically necessary?	❑ Yes (Continue with this form). ❑ No (Complete #'s 2, 25, & 26 then end the call). **See explanation below

**An exclusion occurs when the policy purchased does not come with weight-loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy, that means the surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight-loss surgery, they are simply saying that are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.

Insurance Review Form		
Number	**Question for Representative**	**Answer from Representative**
2	Please have the representative read the benefit OR exclusion to you. Write it down word-for-word. This will tell you what documentation is required to prove medical necessity. (e.g. physician supervised diet, psych evaluation, BMI criteria, etc.).	
3	Am I required to have weight-loss surgery at a Center of Excellence facility?	
4	Is SSM Health Weight Management Services St. Mary's Hospital - Centralia, IL (Dr. Deepu Sudhakaran) in my network? Tax ID# 471971947	
5	Is SSM Health Good Samaritan Hospital in my network? Tax ID #: 37-0662580	
6	What is the effective date of my policy?	
7	What is the calendar year renewal date?	
8	Do I have a pre-existing clause?	
9	If yes, what is the end date of the pre-existing clause?	
10	Is a referral from my Primary Care Physician required?	
11	What is the deductible per calendar year?	
12	How much have I met towards my deductible?	
13	What is the maximum out-of-pocket per calendar year?	
14	How much have I met towards my maximum out-of-pocket?	
15	Is the deductible applied to the maximum out-of-pocket?	
16	What is the co-insurance percent for my policy?	
17	What are my financial obligations to the doctor for inpatient surgery?	
18	What are my financial obligations to the doctor for outpatient surgery?	
19	What are my financial obligations to the hospital for inpatient surgery?	

Insurance Review Form

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Insurance Review Form		
Number	**Question for Representative**	**Answer from Representative**
20	What are my financial obligations to the hospital for outpatient surgery?	
21	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
22	Does physical therapy require pre-certification?	
23	What is my copay for a specialist office visit?	
24	What is the fax number for pre-determination?	
25	Name of the representative	
26	Date/time you spoke to representative	
27	If you have an exclusion in your policy, would you like to self-pay for surgery? If yes, we will proceed with your process. If no, your process will stop.	❑ Yes ❑ No

Disclaimer:

- SSM Health Weight Management Services – Dr. Sudhakaran and SSM Health St. Mary's Hospital – Centralia, IL are not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight-loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by SSM Health Weight Management Services – Dr. Sudhakaran.

By signing below, I certify the following:

- I have read and understand the instructions that were provided to me.
- I have read and understand the disclaimer which includes that I am not approved for surgery.
- I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.

Patient Signature: _____

Date: _____ Time: _____

Medical History

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Date: _____ / _____ / _____

Name: _____

Birthday: _____ / _____ / _____

Height: _____ ft. _____in. Weight: _____ lbs BMI: _____ Age:_____

Life Satisfaction: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 **(1 being least happy – 5 being very happy)**

Questionnaire | Diet and Nutrition History

You must include weight loss and dates for all diet attempts within the last 3-4 years. You may add additional lines/pages

MD Supervised Programs	How Long	Pounds Lost	Dates (mm/yyyy)
Medi-Fast			
Opti-Fast			
New Start			
Other:			
Commercial Diets	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Weight Watchers			
Diet Workshop			
Jenny Craig			
Overeaters Anonymous			
TOPS			
Nutrisystem			
Other:			
Prescription Weight Loss	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Redux (dexfenfluramine)			
Pondimin (fenfluramine)			
Fen/Phen			
Phentermine/Fastin/Adipex			
Meridia			
Zenical			
Other:			
Liquid Diets	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
HMR			
SlimFast			
Other:			

Questionnaire | Diet and Nutrition History

You must include weight loss and dates for all diet attempts within the last 3-4 years. You may add additional lines/pages

Therapy & Other Programs	How Long	Pounds Lost	Dates (mm/yyyy)
Behavior Therapy			
Psychotherapy			
Exercise Programs			
Fitness Centers			
Other:			
Herbal & Non-Prescription	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Ephedra/Ma Huang			
Accutrim			
Dexatrim			
Diurex			
Relacore			
Cortaslim			
Other:			
Medical & Healthcare Treatments	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Other Surgery			
Acupuncture			
Hypnosis			
Other:			
Miscellaneous Diets	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Atkins Diet			
Grapefruit Diet			
Cabbage Soup Diet			
Self-Imposed Fast			
Herbal			
Low Calorie			
Low Fat			
Low Sugar			
Book/Magazine			
High Protein			
The Zone			

Questionnaire | Diet and Nutrition History

You must include weight loss and dates for all diet attempts within the last 3-4 years. You may add additional lines/pages

Miscellaneous Diets	How Long	Pounds Lost	Dates (mm/yyyy)
South Beach			
Mayo Clinic			
Blood Type Diet			
Body for Life			
Sugar Busters			
Other:			
Please Describe:			

Which Bariatric Procedure do you wish to pursue?

- ❑ Laparoscopic Roux-en-Y Divided Gastric Bypass
- ❑ Laparoscopic Gastric Sleeve

Obesity History

Years at current weight? _____

Age patient started to diet? _____

Years at 35 pounds overweight? _____

Maximum weight reached? _____

Years 100 pounds overweight? _____

Most significant weight loss

Amount of weight loss _____

Months weight loss sustained _____

Method of weight loss _____

Eating Habits

Volume Eaters ❑ **Yes** ❑ **No**

Sweet Eater ❑ **Yes** ❑ **No**

All day long ❑ **Yes** ❑ **No**

Snacker/Grazer ❑ **Yes** ❑ **No**

Social History/Personal Habits

Do you currently use tobacco products? ❑ Yes ❑ No

If yes: Type _____

How much/How often (example: ½ pack per day)? _____

Are you interested in quitting? ❑ Yes ❑ No

Have you used tobacco products in the past? ❑ Yes ❑ No

If yes: Type _____

How much/How often (example: ½ pack per day)? _____

What date did you quit? _____

Do you currently drink alcohol? ❑ Yes ❑ No

If no: Have you in the past? ❑ Yes ❑ No

If you answered yes to either of the above questions:

Frequency _____Quantity _____

Have you ever felt like you should cut down on your drinking? ❑ Yes ❑ No

Have people criticized your drinking? ❑ Yes ❑ No

Have you ever felt bad or guilty about your drinking? ❑ Yes ❑ No

Have you ever had to have a drink first thing in the morning to steady your nerves or get over a hangover? ❑ Yes ❑ No

Have you ever had black-outs or memory loss from drinking too much? ❑ Yes ❑ No

Have you ever used any drugs such as marijuana, cocaine, stimulants, sedatives, narcotics, diet pills or other substance?

Type	Quantity/Pattern of Use	Injected	How Long/ Last Use

Medical History

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Past Medical History

Please indicate if you have ever been diagnosed with the following problems.

Problem	Current	Past	Date of Diagnosis	Describe
Angina				
Anemia				
Anxiety				
Arthritis				
Asthma				
Bladder Infections				
Blood Clots				
Bleeding Disorders				
CAD				
Cardiomyopathy				
Chest Pain with Exertion				
Cholelithiasis				
CVA				
Chronic Diarrhea				
Colon/Intestinal Polyps				
DVT (Deep Vein Thrombosis)				
Diabetes Type 1				
Diabetes Type 2				
Dyspnea with Exertion				
Depression				
Emotional Problems				
Epilepsy or Seizures				
Elevated Liver Enzymes				
Fatty Liver (non-alcoholic)				
Fibrocystic Breast Disease				
Fibromyalgia				
GERD				
Gout				
Gallbladder Stones/Disease				
Heartburn (Acid Reflux)				
Hemorrhoids				

Medical History

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Past Medical History

Please indicate if you have ever been diagnosed with the following problems.

Problem	Curent	Past	Date of Diagnosis	Describe
Hypercholesterolemia				
Hypertension				
Hypothyroidism				
Inflammatory Joint Pain				
Kidney Stones/Disease				
Liver Disease/Hepatitis				
Lower Extremity Edema				
Lung Disease/Pneumonia				
Myocardial Infarction				
Osteoarthritis				
Pancreatitis				
Peptic Ulcer				
Peripheral Edema				
Peripheral Vascular Disease (PVD)				
Pulmonary Embolism				
Rheumatic Fever				
Sleep Apnea				
Sleep Disorder				
Snoring				
Skin Disorder/Disease				
Stroke				
Sexually Transmitted Disease (STD)				
Thrombophlebitis				
Thyroid Disease/Goiter				
Tuberculosis				
Tumors/Cancer				
Ulcers (Stomach or Intestinal)				
Other:				
Other:				
Other:				

Medical History

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Past Surgical History

Please list all past surgical procedures and year performed.

Procedure Name	Date

Medication Allergies

Drug Name	Reaction

Family History

Please circle Yes or No. Include health issues of each family member in addition to cause of death.

Family Member	Deceased	Cause of Death	Significant Health Issues (Ex: Diabetes, Cancer, High Cholesterol)
Mother	❑ Yes ❑ No		
Father	❑ Yes ❑ No		
Maternal Grandmother	❑ Yes ❑ No		
Maternal Grandfather	❑ Yes ❑ No		
Paternal Grandmother	❑ Yes ❑ No		
Paternal Grandfather	❑ Yes ❑ No		
Brother/Sister	❑ Yes ❑ No		
Brother/Sister	❑ Yes ❑ No		
Brother/Sister	❑ Yes ❑ No		
Brother/Sister	❑ Yes ❑ No		
Brother/Sister	❑ Yes ❑ No		
Other	❑ Yes ❑ No		
Other	❑ Yes ❑ No		
Other	❑ Yes ❑ No		

Patient Demographic Sticker

Current Medications

Please refer to your medication bottle for correct strength and dosage. Please list all vitamins and supplements last.

Name of Medication	Dose & how many times per day	Why do you take this medication?	How long have you been on this medication?
EXAMPLE: Aspirin	**EXAMPLE:** 81mg | once a day	**EXAMPLE:** Prevent blood clots	**EXAMPLE:** 6 months

Sleep History Questionnaire

Have you ever been diagnosed with Sleep Apnea? ❑ Yes ❑ No

If yes: Do you have a device to wear during sleep hours? ❑ Yes ❑ No

What device? ❑ CPAP ❑ BiPAP ❑ Other _____

Do you actually wear the device? ❑ Yes ❑ No

Symptoms During Sleep (Check all that apply)

- ❑ Loud snoring
- ❑ Sinus symptoms interfere with sleep
- ❑ Gasping
- ❑ Heartburn, indigestion, sour taste
- ❑ Daytime sleepiness
- ❑ Inability to move while going to sleep or waking up
- ❑ Difficulty falling asleep/staying asleep
- ❑ Vivid or life-like visions (people in room, etc.) while going to sleep or waking up
- ❑ Depression
- ❑ Awaken too early
- ❑ Sudden weakness/feel your body go limp when angry or excited
- ❑ Inability to concentrate
- ❑ Irresistible urge to move legs or arms
- ❑ Fatigue
- ❑ Creeping or crawling sensation in legs before falling asleep
- ❑ Morning headaches
- ❑ Legs or arms jerking during sleep
- ❑ Irritability
- ❑ Frequent urination disrupting sleep
- ❑ Sleep talking or sleep walking
- ❑ “I worry that I won’t be able to fall asleep”
- ❑ Excessive sweating during the night

Sleep History Questionnaire

Sleep Habits

1. At what time do you usually get to bed? _____

2. How long does it take to fall asleep after lights out? _____

3. How often do you awaken at night?_____

4. Total time spent awake in bed? _____

5. I usually wake up at: _____

6. Total length of naps daily? _____

7. Do you work a rotating shift? _____

8. Do you have an unusual work schedule? _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these things, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 – would never doze **1** – slight chance **2** – moderate chance of dozing **3** – high chance of dozing

___ Sitting and reading

___ Watching TV

___ Sitting, inactive in a public place

___ As a passenger in a car for an hour without a break

___ Lying down to rest in the afternoon

___ Sitting and talking with someone

___ Sitting quietly after lunch with alcohol use

___ In a car, while stopped for a few

___ **Total points**

Medical History

SSM HEALTH
WEIGHT MANAGEMENT SERVICES

Patient Demographic Sticker

Please provide us any additional information you feel would be beneficial to share with your health care provider/insurance company in regards to your current or past medical history:

Signature of Patient: _____ Date/Time: _____

_____

Signature of Person Completing Questionnaire (if not the patient) Relation to Patient Date/Time

Patient Demographic Sticker

Pre-Operative Immunization Waiver Form

I,_____ do not want pneumonia and influenza immunization to be given 1 month prior or 1 month after the scheduled surgery date. If I so want to be immunized I will obtain the immunization before or after the above stated time period.

Signature of Patient: _____ Date/Time: _____

Patient Demographic Sticker

Primary Care Physician Referral Form
(Must be filled out by your physician)

Dear SSM Health Weight Management Services St. Mary's Hospital – Centralia, IL:

I am referring my patient _____, date of birth _____ , to you for your opinion regarding the possibility of weight-loss options, including surgery.

The patient's **current weight is:** _____ **height is:** __ ft __ in **BMI is:** _____ kg/msq

The patient has been morbidly obese for _____ years.

The patient suffers from the following co-morbid conditions associated with morbid obesity. (Check all that apply)

- ❑ Type 2 diabetes – controlled by oral medications
- ❑ Type 2 diabetes – controlled by injectable medications
- ❑ Obstructive sleep apnea
- ❑ Coronary artery disease _____
- ❑ Valvular heart disease
- ❑ History of medical non-compliance
- ❑ Dyslipidemia
- ❑ Stress incontinence
- ❑ GERD
- ❑ Heartburn
- ❑ Arthritis
- ❑ Hypertension

The patient also has the following conditions that are associated with morbid obesity:

_____ _____ _____

_____ _____ _____

The patient has a current/history of:

- ❑ Schizophrenia, psychosis, thought disorders
- ❑ Consistent difficulty in coping with stress
- ❑ Suicide attempts or psychiatric hospitalizations
- ❑ Substance abuse or eating disorders

I have completed the following diagnostic work-up on this patient in the past year. I will be forwarding a copy of these reports to your office to assist with your evaluation of my patient (Check all that apply)

- ❑ Sleep study
- ❑ Venous duplex
- ❑ Exercise stress test
- ❑ Pulmonary function test
- ❑ Laboratory testing such as lipid panel and Hgb A1C
- ❑ Other _____

Patient Demographic Sticker

Primary Care Physician Referral Form

(Must be filled out by your physician)

The patient has attempted medically-managed weight loss as well as other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. Please render your opinion on appropriate management options.

Sincerely,

_____

Signature (required) Date/Time Phone

_____

Printed Name Address (required)

Your Psychological Evaluation

All information included in this packet has been designed to help you through the process of getting your psychological evaluation and to explain why this part of our program is required.

A few important notes:

1. The psychological evaluation is not required for your first office visit.
2. Your psychological evaluation IS REQUIRED for our program. Typically, we cannot submit for insurance approval without your psychological evaluation.
3. Please make your appointment with ONLY a Licensed Psychologist, Psychiatrist, Psychiatric Nurse Practitioner or Licensed Clinical Social Worker, unless approved by your surgeon.
4. You are responsible for making your initial psychological evaluation appointment.
5. We STRONGLY SUGGEST that you begin this process as quickly as possible. Typically, the faster this is completed, the faster you can have surgery.
6. For your convenience, we have enclosed a list of practitioners who have done evaluations for our clinic before. Please note: we do not require you to go to any of these practitioners. You may see anyone who meets the above criteria.
7. We have included in this packet the evaluation information that the provider should use as reference when completing your evaluation. You will need to take these forms with you to your appointment. A complete evaluation and consultation report is required. A simple letter stating that you have been cleared for surgery is unacceptable.
8. Please be aware that it may take some time for the evaluation to be scheduled and for the licensed psychologist or psychiatrist to complete and send your evaluation to our office. Once it is complete, please have it sent to us as soon as possible.

   You can fax it to: **618-436-6105**
   Attention: **Weight Management**

IF YOU HAVE QUESTIONS, PLEASE CONTACT US AT 618-436-8300.

Psychological Evaluation Information

Please find the list enclosed of psychological providers who are available to do psychological evaluations, pre-operative psychotherapy and follow-up psychotherapy. All have had experience with bariatric patients and the bariatric assessment procedure. However, each provider is unique in how they perform their evaluation and what they charge for their services. You may want to ask questions about the amount of time needed to complete the evaluation and what the normal or typical fee is associated with the service. Also, if there are other providers you would like to complete your evaluation and do not find his/her name listed, please phone "Program Name" to ensure that your evaluation will meet the requirements of the programs.

Insurance & Scheduling Procedures
Pre-Operative Psychological Assessment For Bariatric Surgery Patients

Pre-surgical psychological assessment is a standard requirement before patients undergo bariatric surgery. Nearly all insurance companies require a psychological evaluation before they will authorize surgery. Unfortunately, insurance companies are very inconsistent about how they cover the pre-surgical psychological assessment.

Although the psychological assessment is not required because of existing or suspected mental/behavioral problems, the mental/behavior department of your medical insurance will likely authorize and pay for the psychological evaluation. Certain insurance carriers will not pay for a pre-surgical psychological evaluation. In the event that your insurance policy does not allow coverage for this evaluation, please be aware that payment for your evaluation will be expected at the time of service.

The provider performing this assessment should have office staff to help identify your insurance coverage for this assessment. You may ask them to help you with this; however, it is critical that you take the steps required of you, including obtaining pre-authorization for the assessment or arranging for payment at the time of service.

Please note: Some providers may require a referral prior to scheduling your evaluation. Our office is unable to provide this referral until after you have completed your initial consultation with Dr. Sudhakaran. Your primary care physician may be willing to issue this referral for you prior to your consultation in our office.

Dear Licensed Psychologist or Psychiatrist:

SSM Health Weight Management Services St. Mary's Hospital - Centralia, IL requires that all potential patients seeking weight-loss surgery complete a bariatric psychological screening evaluation. **These evaluations must be done by a Licensed Psychologist, Psychiatrist, Psychiatric Nurse Practitioner or Licensed Clinical Social Worker, unless an alternative provider is approved by Dr. Sudhakaran and your Insurance Company.**

As no standard evaluation tool exists for bariatric screening evaluations, we would like to make the following recommendations regarding the interview process to help focus on those issues we commonly see as pitfalls to success in weight-loss surgery patients. We would like you to address these particular issues in your interview process.

- Reporting or displaying of adverse psychiatric conditions that might contraindicate surgery such as severe depression, severe neurosis or severe behavioral eating disorders. These conditions should not be active at the time of the evaluation. Controlled condition, even on those medications, are acceptable and should by documented.
- The patient should be able to describe the physical aspects of the procedure and be able to have an active discussion regarding the long-and short-term risks and benefits of the operation. They should also be able to outline realistic expectations regarding post-operative plans, recovery and outcomes. If they are unable to do this, it is important that we know this from your evaluation.
- Assessment should be given to the support systems of the patient. Are adequate support systems in place to help the patient through the recovery process? Any barriers to adequate support or the patient's unwillingness to seek therapy as a result of issues that occur from weight loss should be noted.
- The patient should also be able to verbalize negative outcomes associated with non-compliance with the program. A history of medical non-compliance should also be assessed, addressed and documented as appropriate.
- The patient should also be able to verbalize that weight-loss surgery will likely not improve issues such as negative body image and diminished self-esteem. Education should be given psychological assistance in the post-operative period.

Evaluation

While the ultimate responsibility for weight-loss surgery rests in our hands and those of the patient, your recommendations for the patient's success are critical. In this evaluation report, we must see from you, in writing, one of the following statements:

- Clearance from psychiatric evaluation for surgical weight loss.
- Clearance from psychiatric evaluation for surgical weight loss with recommendations: Include recommendations and follow-up plan.
- The patient will need to be reevaluated before psychiatric clearance is given for the surgical evaluation. The patient must complete the following recommendations before the reevaluation can occur: Include recommendations and follow-up plan/reevaluation schedule.
- The patient is NOT given psychiatric clearance for surgical evaluation for the documented following reasons or concerns.

Please support your recommendations with documentation from the interview and evaluation. A dictated report is appreciated as opposed to hand-written notes. Common recommendations for patients that we see include mandatory attendance in bariatric support groups, additional therapy sessions to work on specific issues that may affect the patient's success, letters from primary care physicians noting the patient's compliance with medical therapies, completion of a relapse prevention plan, etc.

Our office requires a full evaluation. Reports received that contain only a few sentences and state "the patient is cleared for bariatric surgery" will not be accepted. Also, reports that include only scoring from the evaluation of standardized tests will not be accepted.

If you have any questions, please feel free to contact us at **618-436-8300**. You may send your evaluation via fax to **618-436-6105**.

Psychology and Psychiatry Services Available in the Area

Dr. Fred Klug	**618-327-8236**
Dr. Lydia Williams	**618-242-4205**
Dr. Naeem Qureshi	**618-998-0888**
Dr. Reno Ahuja	**618-942-8645**
Dr. Julie Handwerk	**618-937-1111**
Matt Denis, PhD	**618-457-4488**
Frank Kosmicki, PhD	**618-203-6730**
Gordon Plumb, PhD	**618-529-2273**
Monika Plumb, PhD	**618-529-2273**
Angela Center	**618-436-6556**

****The following accept Medicaid patients****

Dr. Qureshi – Anna Office	**618-833-4471**
P. Talapatra, LCSW	**618-997-3647**
E. Floyd-Kennett, LCSW	**618-273-7723**
J. Cooley, PhD	**618-773-7723**
L. Schmider, PhD	**618-457-6703**

Patient Demographic Sticker

Notice Of Privacy Practices Acknowledgement Of Receipt

I have received on this visit/admission or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. The Notice of Privacy Practices is also available on the SSM Health website. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

_____

First Name MI Last Name Date of Birth

_____

Signature of Patient/Parent or Legal Guardian Date/Time

Patient Record Of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request restriction on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or a communication of PHI may be made by alternative means such as: sending correspondence to the individual's office or cell phone, instead of the individual's home phone.

Please check all that apply (Indicate with a "P" primary method of communication)

Home Telephone:
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

My Chart:
- ❑ OK to send message with detailed information

Work Telephone:
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

Other (list below):
- ❑ _____

Written Communication:
- ❑ OK to mail to: _____
- ❑ OK to fax to: _____

Email:
- ❑ OK to send message with detailed information to: _____

Cell Phone:
- ❑ Leave message with detailed information
- ❑ Leave message with call back number only

I give consent to SSM Health Weight Management Services to release/discuss details of my medical care, including test results, medications, appointments and other information with the persons listed below:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD.