SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-622-6453 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

Thank you for your interest in the weight-loss programs offered at the SSM Weight-Loss Institute. Inside this brochure you will find information on the weight-loss options we offer. To pursue either option, surgical or non-surgical, we recommend attending free educational seminars. Dates for surgical seminars and non-surgical orientations can be obtained on-line. Additionally, for your convenience, the surgical seminar can be completed on-line at ssmweightloss.com.

If you are inquiring into weight-loss surgery options it is strongly recommended that you call your insurance company and inquire about your benefits, the criteria, and pre-authorization for surgical treatment of morbid obesity. When inquiring about your benefits your insurance company may request a procedural code, commonly referred to as a CPT code. The CPT code for gastric bypass is 43644, adjustable gastric banding is 43770 and the sleeve gastrectomy is 43775. Please note that not all health insurance policies cover surgery for obesity.

If you are interested in pursuing surgical weight-loss options through the Institute, the paperwork needed to begin the process is attached. Once completed the paperwork can either be scanned back to us at Lindsey_Diehl@ssmhc.com or faxed to 314-622-6453 Att: PreOP

Your timely completion of these items will expedite the process of obtaining your surgical approval.

Patient Registration Form: Please complete including primary and secondary insurance information if applicable and sign at the bottom. **A copy of your insurance card(s) front and back must be included to process your packet.**

Patient Medical Questionnaire: Please complete this questionnaire in its entirety. Please be sure to mark the your choice of surgical tool at the top of the page and include all medications and physician information.

Primary Care Physician Request Form: This form is to be utilized as a tool for your primary care physician on what the Weight-Loss Institute will need to support your request for weight-loss surgery. Please take it with you to your appointment so he/she knows what information is needed. This form can be forwarded to your physician and requested to be faxed to the fax number listed at the top of the page when complete. You do not need to wait for this form to be completed to return the rest of the packet. We will match all items in the office once received.

Privacy Practices: Please complete and return with appropriate person(s) noted to have permission by you to speak with. This will help assist us in best contacts.

Once the paperwork is completed and returned to our office your information will be processed, insurance verified and you will be contacted as to your next steps.

Please note some insurance policies require referrals from your primary care physician for visits with our specialists in the Weight-Loss Institute. You can contact your insurance company directly or ask your primary if required. Insurance referrals are the responsibility of the patient and must be obtained prior to scheduled appointments to avoid cancellation.

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PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME _____ FIRST NAME & INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PAGER _____

HOME PHONE _____ CELL PHONE _____ E-MAIL _____

DATE OF BIRTH _____ SEX: ☐ M ☐ F AGE: _____ MARITAL STATUS: ☐ Married ☐ Single RACE: _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____

SPOUSE'S NAME _____ SPOUSE'S DOB _____ SPOUSE'S WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PATIENT SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

PATIENT EMPLOYER _____ EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE _____ EXT. _____

GUARANTOR

RESPONSIBLE PARTY LAST NAME _____ FIRST NAME & INITIAL _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ RESPONSIBLE PARTY SOCIAL SECURITY # _____ DOB _____

RESPONSIBLE PARTY EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

INSURANCE INFORMATION

1. MEDICARE OR INSURANCE #1 NAME _____

MEDICARE OR INSURANCE #1 ADDRESS _____ MED. OR INS. #1 PHONE _____

POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

2. MEDICARE OR INSURANCE #2 NAME _____

MEDICARE OR INSURANCE #2 ADDRESS _____ MED. OR INS. #2 PHONE _____

POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

I request payment of authorized Medicare, Medigap or any other insurance benefits be made on my behalf to Weight Loss Institute for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or to other insurers any information needed to determine benefits payable for services from the provider. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

FINANCIAL LIABILITY: I understand I am fully responsible for all Physician charges. If I have insurance that will cover a portion of my bill, I agree to pay the patient's portion of the bill and understand I may be required to make a deposit toward the amount and the balance. The fact I may be covered by insurance does not relieve my personal obligations to pay all charges. I agree to assure payment of all charges by Weight Loss Institute.

All of the above information I have given is to the best of my knowledge correct.

SIGNATURE _____ **DATE** _____

SSM Weight-Loss Institute

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PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire in its entirety.
Please be sure to mark the your choice of surgical tool at the top of the page and include all medications and physician information.

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ GENDER _____

HEIGHT _____ WEIGHT_____

HOW LONG AT CURRENT WEIGHT _____ OCCUPATION _____
☐ FULL TIME ☐ PART TIME

Which weight loss option are you interested in?
☐ Surgical ☐ Non-surgical ☐ Both
☐ Roux-en-y Divided Gastric Bypass ☐ Adjustable Gastric Band
☐ Sleeve Gastrectomy ☐ Revision – please obtain medical records from previous surgeon

How did you hear about the SSM Weight Loss Institute? _____

Surgeon requested: ☐ Dr. Mario Morales ☐ Dr. Andrew Wheeler

CURRENT MEDICATIONS

INCLUDING VITAMINS, OVER-THE-COUNTER MEDICATION, AND INTERMITTENTLY USED DRUGS.
(Please list prescription medication first)

Name	Strength	Frequency	Purpose	When Started

ALLERGIES

LIST ALL DRUG ALLERGIES:

Drug Name	Reaction

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PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

PAST MEDICAL HISTORY

WHAT MEDICAL PROBLEMS ARE CURRENTLY BEING TREATED?

Illness	Date	Treatment	Outcome

PAST SURGICAL HISTORY

LIST ANY SURGERIES:

Surgery	Date	Reason	Physician

PRIMARY HEALTH CARE PROVIDER

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

OTHER HEALTH CARE PROVIDER(S), INCLUDING SPECIALISTS

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

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PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Cardiac:

Have you ever been told you have coronary artery disease? ☐ **Y** ☐ **N**
Have you ever had a heart attack? ☐ **Y** ☐ **N**
If yes, when _____ Stent ☐ **Y** ☐ **N** Bypass Surgery ☐ **Y** ☐ **N**
Have you ever had congestive heart failure? ☐ **Y** ☐ **N**
Have you ever had any heart rhythm abnormalities? ☐ **Y** ☐ **N**
Have you ever had Rheumatic Fever? ☐ **Y** ☐ **N**
Do you have a pacemaker or defibrillator? ☐ **Y** ☐ **N**
If yes, will require implant information: _____

Pulmonary:

Do you experience shortness of breath with physical activity? ☐ **Y** ☐ **N**
Do you have asthma? ☐ **Y** ☐ **N**
Do you have COPD or emphysema? ☐ **Y** ☐ **N**
Do you smoke? ☐ **Y** ☐ **N**
Do you use oxygen at home? ☐ **Y** ☐ **N**
Do you have Sarcoidosis? ☐ **Y** ☐ **N**

Sleep:

Have you been diagnosed with sleep apnea? ☐ **Y** ☐ **N**
If yes - Are you compliant/use your CPAP/Bipap? ☐ **Y** ☐ **N**

Hepatic:

Have you ever had hepatitis? ☐ **Y** ☐ **N**
Have you been told you have cirrhosis of the liver? ☐ **Y** ☐ **N**
Have you ever been told you have a fatty liver disease? ☐ **Y** ☐ **N**
How much alcohol do you drink? _____
Have you ever had problems with alcohol? ☐ **Y** ☐ **N**
If yes, when: _____

Renal:

Are you on Dialysis? ☐ **Y** ☐ **N**
Have you ever had any kidney problems? ☐ **Y** ☐ **N**
If yes, when: _____

Neurological:

Have you ever had a stroke? ☐ **Y** ☐ **N**
Do you have Multiple Sclerosis, Parkinson's disease, or any other neurological disease? ☐ **Y** ☐ **N**
If so, what disease? _____
Do you have Pseudotumor Cerebri? ☐ **Y** ☐ **N**
Do you use a ☐ *wheelchair OR* ☐ *cane*?

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REVIEW OF SYMPTOMS

Gastrointestinal:

Have you ever had (please check all that apply):

☐ *Gallstones* ☐ *Hiatal Hernia* ☐ *Diarrhea* ☐ *Hernia* ☐ *Blood in stool*
☐ *Hemorrhoids* ☐ *Ulcer Disease* ☐ *Crohn's Disease*

Do you have heart burn?	☐ **Y**	☐ **N**
Have you ever had surgery for the treatment of reflux disease?	☐ **Y**	☐ **N**
Have you had any previous weight loss surgery?	☐ **Y**	☐ **N**

Endocrine:

Do you have thyroid disease?	☐ **Y**	☐ **N**
Check which type you have: ☐ *Hyper (high)* ☐ *Hypo (Low)*		
Are you ☐ *diabetic* or ☐ *insulin resistant* or do you have		
☐ *metabolic syndrome* (check)	☐ **Y**	☐ **N**
Do you have high cholesterol or high lipids?	☐ **Y**	☐ **N**
Are you treating your high cholesterol?	☐ **Y**	☐ **N**

Bone or Joint Problems:

Have you ever been told you have degenerative joint changes, or arthritic changes in your joints?	☐ **Y**	☐ **N**
Has treatment included use of steroids?	☐ **Y**	☐ **N**

Psychiatric:

Current Psychiatric treatment?	☐ **Y**	☐ **N**
Treated by: ☐ **Psychiatrist** ☐ **Therapist** ☐ **Psychologist**		
Current Psychiatric Hospitalization (last 12 months):	☐ **Y**	☐ **N**
Treated by: ☐ **Psychologist** ☐ **Psychiatrist**		
Have you ever been diagnosed with an eating disorder?	☐ **Y**	☐ **N**

Past Treatment:

Were you ever hospitalized for Psychiatric treatment?	☐ **Y**	☐ **N**

When was your treatment? _____
Where was your treatment? _____
What was your treatment for? _____

Current Treatment:

Whose care are you under? _____
Current medications and dosages: _____
Current diagnosis and reason for treatment? _____
_____

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REVIEW OF SYMPTOMS

Vascular:

Do you have hypertension?	☐ Y	☐ N
Have you ever had a blood clot?	☐ Y	☐ N
If yes, when _____		
What form of treatment _____		
Have you ever had a Pulmonary Embolus?	☐ Y	☐ N
Do you have a immediate family history of blood clots?	☐ Y	☐ N
Do you get significant swelling in your legs?	☐ Y	☐ N
Have you ever had leg ulcers?	☐ Y	☐ N
Have you ever been treated for cellulites of the lower extremities?	☐ Y	☐ N
Have you ever been told you have peripheral vascular disease?	☐ Y	☐ N
Do you have any history of abnormal bleeding?	☐ Y	☐ N

Infection:

History of MRSA?	☐ Y	☐ N
Do you have an autoimmune disease?	☐ Y	☐ N

If yes please specify: ☐ Lupus ☐ HIV ☐ Aids ☐ Rheumatoid Arthritis
☐ Other (please list) _____

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PSYCH EVAL BACKGROUND INFORMATION

The following information is considered confidential and will be handled as such.

Patient Name _____ DOB _____ Age _____ ☐ Male ☐ Female
Your city and state _____ Highest education level_____

Are you seeking: ☐ Banding ☐ Bypass ☐ Sleeve ☐ Revision Height _____ Weight _____
Married? _____ How long? _____
Which marriage (2nd, etc.) _____ ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Who lives in your home? (wife, kids, etc.) _____ # of children born? _____
Employed where? _____ Job/position? _____ For how long? _____

What do you attribute your excess weight to? (e.g. poor food choices, genetics, large portions, etc.)

_____
At what age or grade were you initially overweight? _____ Highest weight ever? _____
Age or grade you made first dieting attempt _____
If you recall, what did you weigh when you graduated high school? _____
Date of most recent dieting attempt (last year, currently dieting, etc.) _____
Do you binge eat or consider yourself to be a compulsive eater? _____
Are you a grazer (consistent snacker or picker)? _____
Do you eat to compensate for stress _____ boredom _____ emotional comfort _____?
If yes to any of these, how do you plan on controlling these behaviors following weight loss surgery?

_____
_____

Have you ever had a suicide plan or attempt? ☐ Yes ☐ No If so, when? _____
List any current mental health diagnoses, such as depression, anxiety, etc. and any related medications:

_____
Who prescribes the Rx and what is their phone number? _____
How many cigarettes do you smoke per day? _____
How much alcohol do you drink and what type (beer, etc.) _____
List any prior addictions _____
Ever been hospitalized for a psychiatric disorder? _____
Briefly describe your childhood when growing up (chaotic, stable, problematic, etc.) _____
Do you *regularly* feel ☐ anxious ☐ nervous ☐ sad ☐ flat ☐ down ☐ helpless ☐ worthless ☐ guilty
Ever have a visual or auditory hallucination? _____ Trouble sleeping? _____
Does the desire to eat remain about the same over time? _____
Currently under extreme stress? _____ Ever treated for a eating disorder? _____

Medical reasons for seeking bariatric surgery _____
_____

How long have you been thinking about having a weight loss procedure? _____
Ways you have researched the surgery _____
Any other family members who had bariatric surgery? ☐ Yes ☐ No
Who referred you for surgery (self/doctor) _____
Briefly list the surgical risks of the procedure you are seeking _____
_____
What is the most you could weigh and feel like your surgery has still been successful? _____

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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 Care 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

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 that 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

WRITTEN COMMUNICATION:
☐ OK to mail to:_____
☐ OK to fax to: _____

MY CHART:
☐ OK to send message with detailed information: _____

WORK TELEPHONE:
☐ Leave message with detailed information
☐ Leave message with call back number only

CELL PHONE:
☐ Leave message with detailed information
☐ Leave message with call back number only

OTHER (list below):
☐ _____

I give consent to SSM WLI 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

For Office Use:

_____

Entered into system by Date

SSM Weight-Loss Institute