



**\*ASCREENCRIT\***  
**Bariatric Surgery Program**  
**Initial Patient Application**

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Form Origination Date: 5/2016  
 Version: 1

Version Date: (5/2016)

Patient Name \_\_\_\_\_  
 MRN \_\_\_\_\_

**PATIENT IDENTIFICATION LABEL**

**Monthly Consecutive Weight Loss Attempts for Patients Preparing for Bariatric Surgery**

\*This is an *example* of a form that includes the documentation that many insurance companies are looking for when they require 3-6 months of 'medically supervised weight loss'. **SHARE THIS DOCUMENT WITH YOUR PRIMARY CARE PROVIDER; Fax completed forms to 843-876-4201. Call 843-792-3046**

Patient is being evaluated by MUSC for: **gastric bypass** **sleeve gastrectomy** **duodenal switch**  
 Insurance: \_\_\_\_\_ Number of months of 'medically supervised diet' required: \_\_\_\_\_

Month (please circle)      1      2      3      4      5      6      Visit Date: \_\_\_/\_\_\_/\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Height (in): \_\_\_\_\_ Weight (pounds): \_\_\_\_\_ Body Mass Index (kg/m<sup>2</sup>): \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Pertinent Medications: \_\_\_\_\_

**Pertinent Comorbid Conditions/Diagnoses:**

Please circle from most common: Diabetes, Hypertension, Gastrointestinal Reflux, Sleep Apnea, Asthma  
 Other: \_\_\_\_\_

**Treatment Recommendations:** Please indicate what type of diet plan you have recommended

- Calorie-level diet: \_\_\_\_\_ total calories per day or restriction of \_\_\_\_\_ calories/day
- Macronutrient diet:  low carbohydrate  low fat  high protein (Atkins, South Beach)
- Structured Programs:  Weight Watchers  Metabolic Medical Center/Physicians Plan
- Meal Replacements:  Optifast/Medifast  Slim Fast  Jenny Craig  Nutrisystem
- Medications:  OTC (Alli)  Phentermines (\_\_\_mg/d)  Orlistat/Xenical (\_\_\_ mg/d)
- Belviq (\_\_\_ mg/d)  Qsymia (\_\_\_ mg/d)  Other: \_\_\_\_\_

**Exercise Prescription:** Please indicate what type of exercise regimen you have recommended

- Type:  Walking  Swimming  Aerobics  Bike  Resistance training  Going to a Gym
- Program (Curves, Ladies Choice)  Other \_\_\_\_\_
- Duration: \_\_\_\_\_ minutes  Frequency: \_\_\_\_\_ days/week

**Response to prescribed regimen in past month:**  Lost \_\_\_\_\_ pounds  Gained \_\_\_\_\_ pounds

**Goals for next visit:**  lose \_\_\_\_\_ pounds  adhere to diet plan  adhere to exercise regimen

Comments: \_\_\_\_\_ **FOLLOW UP: Return in 1 month**

\_\_\_\_\_  
 Provider Signature

\_\_\_\_\_  
 Provider Name

\_\_\_\_\_  
 Date