Welcome to NGPG Bariatric Process

The following is an outline of what will be required of you, the patient, Dr. Nguyen, Dr. Gill and their Staff.

Patient should call their insurance company to determine if bariatric is a covered service under their policy. This does not guarantee payment. Please refer to your specific Insurance Policy Guidelines.

- Patient is seen in office or comes to a Patient Informational meeting (PI meeting is a requirement).
- Patient’s insurance benefits are verified and the patient is informed if this is a covered service.
- Patient is evaluated to see if he/she meets criteria for bariatric surgery. **Criteria for Bariatric Surgery** is BMI over 40 with no co-morbidities or BMI of 35 with co-morbidities.
- Any patient who has a diagnosis of GERD or epigastric pain or who is having a bariatric surgery other than the band will have an EGD. The patient will be required to have a colonoscopy for any surgical indications as well.

*If the patient has no critical illness the office staff will coordinate the following appointments:*

1. Patient Information meeting
2. Psych evaluation
3. Education class
4. Dietitian Consult
5. Sleep Apnea Screening
6. Letter from the primary care physician supporting patient’s pursuit of weight loss surgery to help control medical co-morbidities

*If the patient has a critical illness the office staff will coordinate the following appointments:*

1. Patient Information meeting
2. Psych evaluation
3. Education class
4. Dietitian Consult
5. Sleep Apnea Screening
6. Letter from the primary care physician supporting patient’s pursuit of weight loss surgery to help control medical co-morbidities
7. Cardiologist – for use of weight loss medication or cardiac clearance for surgery
8. Pulmonologist- for asthma, COPD, etc or clearance for surgery
9. Sleep Study Consult- if necessary
10. Endocrinologist- If necessary

✓ During the Bariatric process the patient is encouraged to try the Stage 4 Bariatric Diet. Weight loss is strongly encouraged. A weight gain is grounds for not proceeding with surgery.
✓ Another determent for surgery will be using tobacco products. The patient MUST have stopped using tobacco products for a minimum of 2 months before surgery. If the patient is still using tobacco products, the surgery WILL NOT be scheduled
✓ If you are currently wearing a CPAP machine you must be compliant in wearing the CPAP as instructed by your pulmonologist. Failure to do so could postpone surgery.
✓ Surgery cancellation will be at the discretion of the surgeon if non-compliance issues are found.
✓ A letter of understanding will be required of all patients and caregivers/support person stating that they understand the entire scope of the surgery and the requirements that are expected of them.
✓ After that, a letter of Medical Necessity will be generated by Dr. Nguyen / Dr. Gill and this letter with all results from the medical referrals will be sent to the patient's insurance company and a pre-determination will be made.
✓ This process can take up to 6 months depending on individual insurance company requirements.
✓ Once the insurance company has approved the pre-determination, a return visit will be scheduled for the patient.
✓ A pre-operative appointment will be made and the patient will come into the office for pre-operative test to be administered to determine how well the patient understands the scope of surgery and what is expected pre-operatively, post-operatively, and for long term care follow-up. At this appointment the 2 week liquid/high protein diet will be discussed and questions will be answered, pre-operative lab work and a chest X-ray will be ordered. Informed consent by the surgeon is obtained. Bariatric Scheduler explains estimated charges due and payment is received. Surgery is scheduled; hospital pre-operative
appointment and 1 week office follow-up appointment is made. Prep instructions for the day before surgery are given.

- At the first post-op appointment the patient will be evaluated as per the post-op guidelines and an appointment to visit the dietitian will be scheduled.

- Dr. Nguyen / Dr. Gill reserves the right to cancel/postpone any surgery due to non-compliance

If you have any question regarding this process please call our office at 770-219-9200
Patient Name ___________________________ DOB ___________________________

IV. EMERGENCY CONTACT INFORMATION:
Last Name: ___________________________ Middle Name: ___________________________ First Name: ___________________________
Phone Number: (_____) _________ - _________ Relationship: ___________________________

V. INSURANCE INFORMATION:
Name of Insured: ___________________________ Group number: ___________________________
Insurance Company: ___________________________ Policy number: ___________________________
Street Address (Line 1): ___________________________ Effective date: ___________________________
City: ___________________________ State: ___________________________ Zip Code: ___________________________
Disabled? Specify if so, apply (Social Security, Medicare, Medicaid, etc.) ___________________________

VI. REFERENCES:
How did you hear about us? Mark all that apply.
☐ Newspaper ☐ Magazine ☐ Internet Search ☐ Website ☐ Television
☐ Radio ☐ Flyers ☐ Friend / Previous Patient ☐ Physician
Other: ___________________________

If a friend/previous patient referred you, what were their names? ___________________________
If a physician referred you:
Who was the physician? ___________________________
Where is the physician located? ___________________________
Physician’s office number? ___________________________

__________________________________________
Signature of Patient or Responsible Party if Patient is a Minor Date

__________________________________________
Signature of Co-Responsible Party
Patient Name ____________________ DOB ____________________

VI. Weight History:

Current Height: _______ Last Known Weight: _________ Heaviest weight: _______

Starting age of obesity: ___ Number of years of obesity: _______

Approximate weight:

As a child (8 - 10 years old): _____ Adults in 31 - 40 years old range: _______

As a teen (13 - 17 years old): _____ Adults in 41 - 50 years old range: _______

Young adult (18 - 30 years old): _____ Adults in 51 - 60 years old range: _______

Immediate family members obese (Y or N): _____ Spouse overweight? (Y or N): _______

VII. Eating Habits:

High volume eater (Y or N): _______ Sweets or high calorie eater (Y or N): _______

Often eat fast foods (Y or N): _______ Guilty of frequent snacking (Y or N): _______

Eat when emotional (Y or N): _______ Eat when stressed (Y or N): _______

Favorite foods:

Food dislikes:

Food allergies:

Typical Breakfast:

Typical Lunch:

Typical Dinner:

Typical Snacks:

VIII. Diet Attempts:

Last attempt to calorie restriction: ___________ Longest duration of diet attempt: ___________

Mark all following diets attempted in past: □ Atkins □ Beach Body □ Calorie Counting

□ Jenny Craig □ Low Fat □ Low Carb □ Slim Fast □ Nutrisystems □ South Beach

□ Optifast □ Others: __________________________

Daily Caffeine consumption (Y or N): _____ Number of drinks with caffeine per day: _______

Daily Carbonated drinks (Y or N): _____ Number of sodas per day: _______

Other liquid calories: ________________________________
Patient Name ___________________________ DOB ____________________

IX. Weight Loss Groups / Physician supervised programs:

1. ___________________________________________ Dates: ______________________
2. ___________________________________________ Dates: ______________________
3. ___________________________________________ Dates: ______________________

X. History of Weight Loss Medications in the Past (Y or N)? ________

1. ___________________________________________ 5. __________________________
2. ___________________________________________ 6. __________________________
3. ___________________________________________ 7. __________________________
4. ___________________________________________ 8. __________________________

XI. Exercise History:

Routine, scheduled exercise (Y or N) _______ Number of times per week? _______
How long with each session? _______

Able to walk unassisted (Y or N) _______ Member of gym (Y or N): _______

Cardiovascular activities: ______________________________________________________

Strength building activities: ______________________________________________________

Used personal trainer before (Y or N) ______
XII. General Medical Conditions / Co-Morbidities

- Insulin dependent DM (E11.9)
- Non-insulin dependent DM (E11.8)
- Depression (F32.9)
- Sleep apnea (G47.30)
- Asthma (J45.909)
- Respiratory disease: (J98.9)
- Hypertension benign (I10)
- COPD (J44.9)
- Hypertension essential (I10)
- Venous insufficiency (I87.2)
- GERD (K21.9))
- NASH (K75.81)
- High total cholesterol (E78.0)
- Hyperlipidemia (E78.5)
- Stress Urinary incontinence female (N39.3)
- Dysmenorrhea (625.3)
- Stress Urinary incontinence male (N39.3)
- Infertility female (N97.9)
- Osteoarthritis (M19.90)
- Infertility male (N46.9)
- Gallstones (K80.20)
- Coronary heart disease (I25.10)
- Polycystic ovary syndrome (E28.2)
- Congestive heart failure (I50.9)
- Cancer: ________________________________

Other medical problems: ____________________________________________

XIII. Surgeries in the past:

1. ________________________________ 6. ________________________________
2. ________________________________ 7. ________________________________
3. ________________________________ 8. ________________________________
4. ________________________________ 9. ________________________________
5. ________________________________ 10. ________________________________
Patient Name ___________________________ DOB __________________

XIV. Medication List and dosage:

1. ________________________________  9. ________________________________
2. ________________________________  10. ________________________________
3. ________________________________  11. ________________________________
4. ________________________________  12. ________________________________
5. ________________________________  13. ________________________________
6. ________________________________  14. ________________________________
7. ________________________________  15. ________________________________
8. ________________________________  16. ________________________________

Drug Allergies (Y or N): _________ If so, name:

1. ________________________________  3. ________________________________
2. ________________________________  4. ________________________________

XV. Social History:

Smoker (Y or N): ______ If so, number packs per day: ______ Number of years: ______

Quit (Y or N): ______ If so, for how long? ______ Med/Patch (Y or N): ______

Drink alcohol (Y or N): ______ If so, how often per week? ______

Quit (Y or N): ______ If so, for how long? ______

Illicit Drugs (Y or N): ______ If so, what drugs tried? __________________________

Quit (Y or N): ______ If so, for how long? ______ Rehab (Y or N): ______

XVI. Family Medical History:

Father: __________________________________________

Mother: __________________________________________

Children: _______________________________________

Siblings: _______________________________________

Grandparents: ________________________________

Others: _______________________________________

**XVII. Review of System:**

<table>
<thead>
<tr>
<th><strong>Neurological:</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle Weakness</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Numbness</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Seizures</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Memory Loss/ Dementia</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gastrointestinal:</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
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</thead>
<tbody>
<tr>
<td>Heart Burn</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Regurgitation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Difficulty Swallowing</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nausea</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Vomiting</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bloating</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Early feeling of fullness</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Rectal Bleeding</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Constipation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**Stool Habits:**

- Previous Colonoscopy □ □

**Cardiac:**

<table>
<thead>
<tr>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
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</thead>
<tbody>
<tr>
<td>Chest pains</td>
<td>□</td>
</tr>
<tr>
<td>Palpations</td>
<td>□</td>
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<tr>
<td>Swollen Feet</td>
<td>□</td>
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</tbody>
</table>

**Respiratory:**

<table>
<thead>
<tr>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
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</thead>
<tbody>
<tr>
<td>Difficulty Breathing</td>
<td>□</td>
</tr>
<tr>
<td>Wheezing</td>
<td>□</td>
</tr>
<tr>
<td>Cough</td>
<td>□</td>
</tr>
</tbody>
</table>
  - Mucus □
  - Blood □
| Short of Breath (When lying flat) | □ |
| Cardiac Cath | □ |
| If yes, when: ________ |
| Cardiac Stress Test | □ |
| If yes, when: ________ |

**Hematologic:**

<table>
<thead>
<tr>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow to heal after cuts</td>
<td>□</td>
</tr>
<tr>
<td>Easily bruise or heal</td>
<td>□</td>
</tr>
<tr>
<td>Anemia</td>
<td>□</td>
</tr>
<tr>
<td>Past transfusion</td>
<td>□</td>
</tr>
</tbody>
</table>

**Results:**

<table>
<thead>
<tr>
<th><strong>Breast:</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Mass</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nipple Discharge</td>
<td>□</td>
<td>□</td>
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<tr>
<td>If yes, what color? ________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Pain/Tenderness</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Changes in appearance</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Family History Breast Cancer</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Musculoskeletal:</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Knee Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ankle Pain</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Genitourinary:</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Incontinence</td>
<td>□</td>
<td></td>
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<tr>
<td>Painful Urination</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
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 recently. Even if you have not done some of these things recently, 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 of dozing  
2 = MODERATE CHANCE of dozing  
3 = HIGH CHANCE of dozing

Sitting and reading ______________________
Watching TV ______________________
Sitting, inactive in a public place (theater, meeting, etc.) ______________________
As a passenger in a car for an hour without a break ______________________
Lying down to rest in the afternoon when circumstances permit ______________________
Sitting and talking with someone ______________________
Sitting quietly after lunch without alcohol ______________________
In a car, while stopping for a few minutes in traffic ______________________

TOTAL ______________________
During the last month, on how many nights or days per week have you had or been told you had the following (please check only one box per questions):

<table>
<thead>
<tr>
<th>Account Number:</th>
<th>(0) Never</th>
<th>(1) Rarely (less than once a week)</th>
<th>(2) Sometimes (1-2 times per week)</th>
<th>(3) Frequently (3-4 times per week)</th>
<th>(4) Always (5-7 times per week)</th>
<th>(.) Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending MD:</td>
<td></td>
<td></td>
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<tr>
<td>Dr. Nguyen / Dr. Gill</td>
<td></td>
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<tr>
<td>Gender:</td>
<td></td>
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</tr>
<tr>
<td>1. Loud Snoring</td>
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<tr>
<td>2. Your legs feel jumpy or jerky</td>
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<td>( )</td>
<td>( )</td>
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<tr>
<td>3. Difficulty falling asleep</td>
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<td>( )</td>
<td>( )</td>
<td>( )</td>
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<tr>
<td>4. Frequent awakenings</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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<tr>
<td>5. Snoring or gasping</td>
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<tr>
<td>6. Falling asleep when at work</td>
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<td>( )</td>
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<tr>
<td>7. Frequent tossing, turning or thrashing</td>
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<td>( )</td>
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<td>( )</td>
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<tr>
<td>8. Your breathing stops or you choke or struggle for breath</td>
<td>( )</td>
<td>( )</td>
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<td>( )</td>
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<td>( )</td>
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<tr>
<td>9. Excessive sleepiness</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>10. Morning headaches</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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<td>( )</td>
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<tr>
<td>11. Falling asleep while driving</td>
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<td>( )</td>
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<tr>
<td>12. Feeling paralyzed, unable to move for short periods when falling asleep or awakening</td>
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<td>( )</td>
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<tr>
<td>13. Find yourself in a vivid dreamlike state when falling asleep or awakening even though you know you are awake</td>
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<td>( )</td>
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<td>( )</td>
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<tr>
<td>14. Any snoring</td>
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</tbody>
</table>

Patient Name: __________________________ Room: _________ DOB: _______ HT: _______ Age: ______

Wt: ______ BMI: ______ PCP: ___________________________ Tech Name: ___________________________ MIC: ______
Weight Loss Journey

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________

Name of program or medication: ____________________________
Dates of program: From: ________________ to: ________________
Weight loss: ________________ Weight regained: ________________
Patient Name ___________________________ DOB ___________________ Date ___________________

Contact Form

Please list the best telephone number to reach you: ____________________________

Please list the best time to call you. Please be as specific as possible

Day of the week: ____________________________
Morning: ____________________________
Afternoon: ____________________________
Evening: ____________________________

If you work or have regularly scheduled commitments, please list those dates and times.

________________________________________________________________________

________________________________________________________________________

May we leave a message for you?

At home: ____________________________
At work: ____________________________
On your cell: ____________________________

May we speak with anyone other than yourself regarding your medical conditions, appointments, application status, insurance status or any other items relating to you?

Please note that we will always contact you first, unless you indicate otherwise

If yes, please list that person’s name, their relationship to you and how we may reach this person.

Name: ____________________________ Relationship: ____________________________
Telephone number: ____________________________ Alternative telephone number: ____________________________

Signature: ____________________________ Date: ____________________________
Patient Full Name ___________________________ DOB ___________ Date ___________

I hereby authorize the provider or group named below:

Provider/Group Name: ___________________________ Phone: ___________________________

Address: __________________________________________ Fax: ___________________________

to disclose protected health information from the medical record of the above-listed patient, as noted here:

( ) Entire Medical Record – this includes specific permission to release all records and other information regarding: psychological notes, drug or alcohol abuse notes, AIDS and other STD related information, all laboratory and x-ray reports, consultation reports, surgical reports and other outpatient reports.

( ) Only specific information/specification time period - ___________________________

This information is to be disclosed to the following:

Northeast Georgia Physician Group
1075 B Jesse Jewell Parkway
Gainesville, Georgia 30501
Phone: 770-219-2100 Fax: 770-219

The purpose of this disclosure is: ( ) Continuing Care ( ) Legal ( ) Insurance ( ) Personal ( ) Transfer to another physician

__________________________________________ ________________________________
Signature...................................................................................... Date

Printed Name:_____________________________________________________

Signer is: ( ) Patient ( ) Authorized Representative

Page 12 of 15
Pre-Surgery Criteria Agreement

- Completed, signed and dated health history, detailed diet history.
- Pre surgery photos may be taken.
- Completion of a mandatory pre surgery psychosocial evaluation, including psychological testing individual consultation and compliance with any other treatment required after individual consultation
- A sleep study will be required of any patient with symptoms of sleep apnea.
  - A CPAP study may be required. If positive, CPAP device must be worn a minimum of three (3) weeks prior to date of surgery.
- Completion of mandatory pre surgical dietary educational session
- Attendance at a Support group
- Signed Understanding of Screening Criteria
- Signed Understanding of Alcohol Consumption
- Signed Understanding of the Plan for Success
- A Written Letter of Understanding
- A Pre-operative Assessment test for Bariatric Surgery

Pre surgery Screening Agreement

- Patient must fall within the national patient criteria standards of BMI (Body Mass Index) of 40 or BMI of 35 with serious co-morbidities including but not limited to: coronary artery disease, hypertension, gastro-esophageal reflux disease, osteoarthritis, diabetes, sleep apnea and/or restrictive airway disease. Patients not falling within these criteria will be considered on a case-by-case basis.
- Psychosocial evaluation is mandatory
- Patients must have no active history of alcohol, drug or tobacco abuse.
- If the patient has any history of adverse reaction to anesthesia, appropriate referral and evaluation will be made.
- Patient must have a designated support person who will assist and encourage them pre and post surgery. Written documentation of this support is required through a Letter of Understanding written by your designed support person.
- Patient is expected to sign written documentation for their commitment to maintaining long-term follow up with Dr. Alex C. Nguyen/ Dr. Sujata Gill.

Patient Signature: ___________________________________________ Date: ________________

Support Person’s Signature: ___________________________________________ Date: ________________
Alcohol Consumption Warning

Alcohol consumption in relation to weight loss surgery is a critical issue and one that all patients need to address and understand. Since the body changes greatly after weight loss, the way alcohol is processed by the liver may also greatly change. Even though the way alcohol is processed by the body is highly individual, some factors remain the same.

Alcohol is toxic to the liver and can ultimately lead to cirrhosis and possibly death.

Some patients with morbid obesity have been shown to have fatty infiltrates in the liver. Usually after weight loss surgery and subsequent weight loss, there is a steady improvement in the amount of fatty infiltrates found in the liver. However, the rapid weight loss experienced after weight loss surgery can also cause damage to the liver. Therefore, the combination of alcohol and rapid weight loss can cause undue stress on the liver and increase the likelihood for potentially fatal liver damage.

Consequently, we cannot stress enough that you should refrain from consuming alcohol for at least 18 months following surgery. After the 18 month period, an occasional alcoholic beverage is acceptable if desired by the patient.

Remember, alcohol is toxic to the liver. This type of surgery greatly increases the effect of alcohol and its toxicity. Therefore all patients are required to sign this commitment letter.

I have read and understand the above warning regarding the results of consuming alcohol after my weight loss surgery. I agree to refrain from consuming alcohol for at least 18 months following weight loss surgery.

Patient Signature: ________________________________ Date: _______________

Support Person’s Signature: ________________________________ Date: _______________
Plan for Success

I understand that my long-term success after weight loss surgery will be heavily determined by my life-long commitment and compliance, and therefore I agree to:

- Maintain a healthy diet, including nutritional guidelines, portion control, fluid intake and vitamin and supplements as recommended by Dr. Alex C. Nguyen / Dr. Sujata Gill
- Maintain an adequate level of exercise and physical activity.
- Regularly attend Support Group meetings for at least one year after my surgery
- Keep all post-operative and follow up visits with Dr. Alex C. Nguyen / Dr. Sujata Gill and any other specialists participating in my care.
- Seek out additional support and education as needed from Dr. Alex C. Nguyen / Dr. Sujata Gill and other medical professionals, friends, family members, group or one-on-one counseling or therapy.
- Maintain personal accountability for myself and my body, including limiting or eliminating alcohol consumption, smoking and the use of tobacco product. By following the recommended post Bariatric surgery nutritional guidelines, and exercise program.
- At any point we have the right to dismiss you from the practice if you are non compliant to the guidelines stated.

I have read and understand the above Plan for Success. I agree to follow these guidelines.

Patient Signature: ____________________________________________ Date: _________________

Support Person’s Signature: __________________________________________ Date: _________________