Welcome

Thank you for attending our seminar and considering CAMC Weight Loss Center to help you take control of obesity and your life. For people suffering from severe obesity and related health conditions, weight-loss surgery may be the solution you have been searching for. Studies demonstrate that weight-loss surgery, as compared to non-surgical treatments, yields the longest period of sustained weight loss in patients who have failed other therapies.

For best results, patients need to actively participate in a multi-disciplinary weight-loss program, which includes nutritional, psychological, and exercise counseling. Our highly trained team is committed to providing the highest level of patient care every step of the way. At CAMC Weight Loss Center, we perform Gastric bypass surgery (both Laparoscopic and Open), the Adjustable Gastric Banding (Lap Band and Realize Band) procedure and Revisional Weight Loss Surgery.

Robert B. Shin, MD, FACS is the Director of CAMC Weight Loss Center. At CAMC Weight Loss Center, he performs Gastric bypass surgery (both Laparoscopic and Open), Adjustable Gastric Banding surgery and Revisional Weight Loss Surgery. He is board certified in Surgery, fellow of the American College of Surgeons and holds active membership with the American Society for Bariatric Surgery, the Society of American Gastrointestinal Endoscopic Surgery, and the International Federation of the Surgery of Obesity. He has written multiple publications on major surgical journals on Morbid Obesity.

If you are interested in pursuing a weight loss surgery, please read the materials provided in this packet and fill out the enclosed Patient Worksheet. It is important to provide as much detail as possible so that we will be better able to assist you and help your start your journey towards a healthier, happier life.

Please complete the forms before your surgical consultation with Dr. Shin or send or fax to:

CAMC Weight Loss Center                  Fax: 304-388-4968

Please note that this is not an overnight process. There are many required steps that involve multiple parties. We will make every effort to expedite this process for you.

In the meantime, you can begin taking positive steps toward your post-surgical success. Read the literature provided in the packet and take the short Quiz to make sure you understand the information presented at today’s seminar. Keep a list of any questions for your upcoming appointments.

We look forward to helping you achieve your health goals

Robert B. Shin, MD, FACS
Director
CAMC Weight Loss Center
Clinical Assistant Professor of Surgery
West Virginia University
Dear Prospective Patients:

Thank you for your participation in CAMC Weight Loss Center Educational Seminar. Your initial surgical consultation can be scheduled after you completed the seminar. Obtaining the approval from your insurance company can be lengthy. CAMC Weight Loss Center will assist you in this process to provide the insurance coverage for the Roux-en-Y gastric bypass or Adjustable Gastric Banding. However, your participation is essential. Here are some of the steps you will need to take:

Review your insurance policy.
Check the “Exclusion of Coverage” or “Certificate of Coverage” section for mention of a specific weight loss surgery option.

Fill out consent form.
If your insurance company requires prior authorization, you will need to fill out a consent form allowing your doctor’s office to release information about your condition to your insurance company.

Complete the Patient Worksheet.
Fill out the information on the Patient Packet to assist CAMC Weight Loss Center in the submission process. A detailed list—supported by appropriate documentation—of the specific weight loss efforts you have tried and failed in the past 5 years (or more) is necessary to show that you have been unable to achieve long-term weight loss without surgery.

Currently, it is mandatory by your insurance companies that we submit your diet or non-surgical weight loss history to obtain necessary approval for your weight loss surgery. **We cannot gather, copy, or organize these for you!**

Get copies of your medical records from your primary care physician and any other healthcare professionals who have treated your obesity and its related medical conditions (such as type 2 diabetes, high blood pressure, sleep apnea, asthma, joint problems, etc)
If you have undergone medically supervised weight loss programs in the past, obtain copies of those records. If you have never been on a medically supervised weight loss program, begin one now (while you are waiting for insurance approval for your weight loss surgery) and be sure to keep copies of your medical records. Currently, most of insurance companies require at least 6 months “Medically supervised diet or weight loss program” within last 2 to 5 years. Your physician must document the followings on monthly basis:

- Your diet plan
- Your weight
- Dietary consultation if necessary or required by your insurance plan
- Recommendation of behavioral life-style modification
- Exercise recommendation
- Proof of weight loss some time during this non-surgical weight loss trial

If you have PEIA, they require 12 months trial within last 2 years.

Letters from your physicians who have supervised your weight loss, including the medication or diet used, your name, and your physician’s letterhead/address and signature can help very much.

Ask your primary care physician for a letter referring you to CAMC Weight Loss Center. The letter should include your height, weight, and body mass index (BMI) history, as well as any health problems you have that may be related to your obesity and the medications or treatments you are receiving for these conditions.

Be patient.
After CAMC Weight Loss Center has sent the appropriate paperwork to your insurance company to request pre-authorization, it could take many weeks before a response is received. While you are waiting to hear, investigate other available options (such as financing the cost of the procedure and making monthly payments) in case your approval is denied.

Thank you.

Sincerely,

Charleston Area Medical Center Weight Loss Center Staff
NAME: _______________________________________________ AGE: __________
DATE OF BIRTH: ____/____/____ SEX: ___Male ___Female SS#: ___________
ADDRESS: _____________________________________________________________
          CITY: ___________ STATE: ___________ ZIP: ___________
HOME PHONE: ___________ WORK PHONE: ___________
CELL PHONE: ___________ E-MAIL: ____________________
SPOUSE OR GAURANTOR’S NAME: _____________________________________
EMPLOYER: ___________________________________________________________
PRIMARY INSURANCE: ________________________________________________
SECONDARY INSURANCE: _____________________________________________
REFERRING OR FAMILY PHYSICIAN & ADDRESS
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
PAST MEDICAL HISTORY:
___Diabetes Mellitus ___Stroke ___Kidney diseases
___Cancer ___GERD/Reflux ___Stress incontinence
___DVT ___Stomach ulcers ___Polycystic ovarian Syndrome
___Pulmonary Embolism ___Sleep Apnea
___High blood pressure ___Lung diseases ___Psychiatric disorders
___High cholesterol ___Neurological diseases ___Hypothyroidism
___Heart diseases ___Arthritis Others: ___________
FAMILY HISTORY:
___Obesity ___Diabetes ___Heart disease ___High blood pressure ___Cancer
___Others, explain
SOCIAL HISTORY:
___Alcohol ________ (Frequency)  
___Smoker ________ ppd ___Ex-smoker, quit _______ years ago

Tel:  304. 388. 4965
Fax:  304. 388. 4968
PAST SURGICAL HISTORY:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

ALLEGIES TO MEDICATIONS:
__None  __Yes, please list below:
______________________________________________________________________________
______________________________________________________________________________

MEDICATIONS (please include doses and frequency):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

REVIEW OF SYSTEMS:
__Weight Gain  __Cold intolerance  __Black stools
__Weight Loss  __Blackouts  __Blood in stools
__Fever  __Heart palpitations  __Frequent urination
__Fatigue  __Chest pain  __Burning with urination
__Dizziness  __Heart attack  __Back pain
__Blurred vision  __Shortness of breath  __Joint pain
__Headache  __Cough  __Easy Bleeding
__Sore throat  __Abdominal pain  __Skin Rash
__Sweats  __Nausea/Vomiting  __Weakness/Paralysis
__Heat intolerance  __Diarrhea/Constipation  __Depression/Anxiety

I hereby authorize Charleston Area Medical Center Weight Loss Center and Dr. Shin to release information regarding my physical condition or treatment to __________________________ (insurance company name(s)). I also authorize the above insurance company(s) to pay directly to Dr. Shin all the benefits due me under the above policy number(s) by reason of services rendered as provided for in the above policy(s). I agree to pay all charges in excess of the amounts paid by the insurance company(s) named above.

SIGNATURE: _______________________________   DATE: ___________________
DIETARY QUESTIONNAIRE

WEIGHT HISTORY:
When did you have problem with your weight first? ________________________________
When did you begin to worry about your weight? ________________________________
Why did you start to worry about your weight? ________________________________
Why do you think you are overweight?
__________________________________________________________________________
Which members of your family are overweight?
__________________________________________________________________________
What was your lowest adult body weight?    Age_____   Weight _____ pounds.
What was your heaviest adult body weight?    Age_____   Weight _____ pounds.
What was your most weight loss?    _______ Pounds.  After what? _________________
What is your goal weight after your weight loss surgery?  _______ Pounds.
When you have regained your lost weight, why do you think this occurred?
__________________________________________________________________________
What do you feel are your barriers to keep your weight off?
___Lack of motivation
___Lack of knowledge about nutrition

___No support (family or friends)
___Time issues
___Others ___________________________
DIETARY HISTORY:
How many meals do you have per day? _______________________________________
Do you frequently skip meals? _____Yes _____No
If you answered yes, which meal(s) do you skip most frequently? And why?
________________________________________________________________________
Who plans the meals? _____________________________________________________
Who cooks? ______________________ And food shopping? _____________________
How many times do you eat out per week?
Which meal(s) do you eat out most frequently? ____Breakfast ____Lunch ____Dinner
How often do you snack between meals? ____0 to 1 ____2 to 4 ____5 to 7 ____Other
What do you snack on?
________________________________________________________________________
List your food cravings (candies, chocolate, fried foods, ice cream, starches, sweets, etc.)
________________________________________________________________________
Do you drink during your meal? ____Yes. ____No.
Do you drink alcoholic beverages? ____Yes. ____No.
How many drinks per week? ________________________________________________
What types of drinks? _____________________________________________________
Do you smoke? ____Yes. ____No. If Yes, how many cigarettes per day? ___________
Do you drink caffeinated coffee? ____Yes. ____No. How many times a day? ________
Do you drink caffeinated tea? ____Yes. ____No. How many times a day? __________
Do you take vitamin, mineral or nutritional supplements? ____Yes, ____No
If Yes, please list them.
________________________________________________________________________
Are you participating any type of special diet or eating plan? ____Yes, ____No
If Yes, please list them.
________________________________________________________________________

DIETARY HABITS:
What triggers for you to eat?
___Hunger ___Anger ___Depression ___Loneliness
___Lack of control ___Boredom ___Family gatherings ___Social situations
How often do you overeat or binge at meals/snacks?
Do you ever feel compulsive about foods?
Do you achieve feeling of fullness?

**POST SURGICAL COMMITMENT:**
What changes do you think you need to make your weight loss surgery successful?

________________________________________________________________________
________________________________________________________________________

How motivated and committed are you to make necessary life-style and dietary changes after your weight loss surgery?

**FOOD ALLEGIES**

________________________________________________________________________
________________________________________________________________________

**FOOD DISLIKES**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**FOOD CHOICE ANALYSIS**

**Daily Food Choices**

<table>
<thead>
<tr>
<th>Category</th>
<th>0 to 1 serving</th>
<th>2 to 3 servings</th>
<th>More than 4 servings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meat, Poultry, Fish</td>
<td></td>
<td>5 to 6 oz.</td>
<td>0 to 4 oz.</td>
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<tr>
<td>Fruits</td>
<td>0 to 1 serving</td>
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<tr>
<td>Vegetables</td>
<td>0 to 1 serving</td>
<td>2 to 3 servings</td>
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<tr>
<td>Whole grain breads, Unsweetened cereals, Starch vegetables (corn, peas, squash, potatoes etc.)</td>
<td>0 to 2 servings</td>
<td>3 to 5 servings</td>
<td>More than 6 servings</td>
</tr>
<tr>
<td>Dairy Products</td>
<td>0 to 1 serving</td>
<td>2 to 3 servings</td>
<td>More than 4 servings</td>
</tr>
<tr>
<td>Foods high in Sugar/Fat (sodas, chips, cookies, candies, pastries, desserts, crackers)</td>
<td>More than 4 times</td>
<td>2 to 3 times</td>
<td>0 to 1 time</td>
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</table>

**Weekly Food Choices**

<table>
<thead>
<tr>
<th>Category</th>
<th>0 to 1 time</th>
<th>2 to 3 times</th>
<th>More than 4 times</th>
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<tbody>
<tr>
<td>Legumes</td>
<td>0 to 1 time</td>
<td>2 to 3 times</td>
<td>More than 4 times</td>
</tr>
<tr>
<td>Fast Foods</td>
<td>6 times or more</td>
<td>3 to 5 times</td>
<td>0 to 2 times</td>
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</table>

**TOTAL SCORES**
**DIETARY HISTORY**

Please list all foods and beverages eaten in each day for **the last 3 days**.

<table>
<thead>
<tr>
<th>Time</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Snacks</th>
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_________________________     ________________________________     _________

NAME             SIGNATURE          DATE
# WEIGHT LOSS PROGRAM / DIET / EXERCISE HISTORY

## Physician Supervised Diet or Weight Loss Programs

<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Dates (from when to when)</th>
<th>Length of Time</th>
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Example:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates Attended</th>
<th>Length of Time</th>
<th>Form of Proof</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Watchers</td>
<td>2000, 2003</td>
<td>6 month, 8 months</td>
<td>Receipts and booklets</td>
</tr>
<tr>
<td>Physician’s Weight Loss</td>
<td>2003</td>
<td>12 months</td>
<td>Carbon copy of check</td>
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</tbody>
</table>

## Organized Diet Programs

(eg. Diet programs by Hospital/Dietitian, Weight Watchers, etc)

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<th>Name</th>
<th>Dates Attended</th>
<th>Length of Time</th>
<th>Form of Proof</th>
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## Medications

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<th>Dates Taken</th>
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<th>Form of Proof</th>
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## Organized Exercise Programs

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<th>Dates Attended</th>
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<th>Form of Proof</th>
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NAME

SIGNATURE

DATE
CONSENT
To release Pre-Weight Loss Surgery Information to Health Insurer

RELEASE OF RECORDS TO HEALTH INSURER OR OTHER THIRD PARTY:
I hereby authorize the release of my Pre-Weight Loss Surgery Information, prepared by CAMC Weight Loss Center, to my health insurer named below for the purpose of receiving health insurance benefits, reimbursements, payments for services, or other similar decisions related to authorization of my weight loss surgery.

A) Please print your health insurer’s name and address here:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

CONTENTS OF RECORDS TO BE RELEASES:
I understand that these Pre-Weight Loss Surgery Information will include data gathered from surgical consultation, dietary consultation, psychological consultation, and all other relevant information gathered by CAMC Weight Loss Center Staff.

PATIENT INFORMED CONSENT:
I understand that, by law, I do not have to consent to the release of this information. However, I willingly choose to release it for the purposes specified above. I understand that it will be the responsibility of the party named in “A” above to protect the confidentiality of the information released to them. I understand that I may revoke this release by means of a written letter, except to the extent that action has been taken in reliance on my consent. This consent will automatically expire after 180 days from the date it is signed. I have had explained to me fully and understand this authorization to release information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. Everything in this form that was not clear to me has been explained to my satisfaction.

A PHOTOCOPY OF THIS RELEASE IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

SIGNATURE:
Print Name ____________________ Signature ____________________ Date of Birth ___________ Today’s Date ___________

Note to Health Insurer:
1. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulation (42 C.F.R. Part 2, Sections 2.31(a) and 2.33) and state regulations prohibited you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.
2. This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating, and acting upon it according to their specific and advanced professional training in health care fields. Please restrict the availability of these records to the appropriate health care providers. These ethical and legal responsibilities are yours. No responsibility can be accepted by the provider or author of these records if this material is made available to any other person who otherwise should not have access to it, including the patient.
3. Redisclosure or retransfer of these records is expressly prohibited, and such redisclosure may subject you to civil and criminal liability.
4. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Patient Consent

I have completed CAMC Weight Loss Center ONLINE Weight Loss Surgery Seminar. I understand the risks and potential complications it describes. I have had my questions answered to my satisfaction regarding the Roux-en-Y gastric bypass or Adjustable Gastric Banding. I understand no all risks connected with a weight loss surgical procedure can be predicted. I also know those risks can be serious, including death. They can be serious even with the best medical and surgical care. I accept all the risks and the possible complications. I believe the benefits I will get from a weight loss surgery outweigh the risks. I take full responsibility for my choice and choose to proceed with the surgical treatment for morbid obesity.

Signed by: _________________________________________ Date _______________

Print or type your name: __________________________________________________
Commitment to Post-Weight Loss Surgery Obligations

I have completed CAMC Weight Loss Center ONLINE Weight Loss Surgery Seminar. I understand that there are numbers of obligations I must be committed after my weight loss surgery. I agree to makes recommended changes (made by CAMC Weight Loss Center Staff) to my life-style, diet and exercise habits. I agree to long-term follow-ups with CAMC Weight Loss Center after my weight loss surgery. I understand that a weight loss surgery is a tool, not the cure for my obesity and obesity-related diseases. I am fully aware of my responsibility in making the changes in life-style, diet and exercise in order to improve my life-quality and health. I have been sufficiently explained of the role of a weight loss surgery and requirements after my surgery by CAMC Weight Loss Center Staff. I take full responsibility for my choice and choose to proceed with the surgical treatment for morbid obesity.

Signed by: _____________________________ Date __________

Print or type your name: ________________________________