



## BARIATRIC PRE-SCREENING ASSESSMENT

### D. Medical Health History

<b>Cardiac (Heart) &amp; Circulation</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Coronary Artery Disease					
Heart Attack (MI)					
Congestive Heart Failure					
Heart Valve Disease					
Heart Murmur					
Rheumatic Fever					
Irregular Heart Beat					
High Blood Pressure					
Chest Pain					
Other Heart Disease					
Elevated Cholesterol					
Elevated Triglycerides					
Blood clots in legs or lungs					
Swelling in hands and feet					
Varicose Veins					

1. Do you see a cardiologist (Heart specialist)?     Yes    No
2. Last EKG \_\_\_\_\_ Was it normal?     Yes    No
3. Any previous Cardiac Testing?     Yes    No. If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

<b>Pulmonary (Lung) &amp; Breathing</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Asthma					
Pneumonia					
Chronic Bronchitis					
COPD (emphysema)					
Tuberculosis					

## BARIATRIC PRE-SCREENING ASSESSMENT

Pulmonary Hypertension					
Sleep Apnea					
Snoring					
Cough					

4. Do you experience shortness of breath:       Yes  No
- a. At rest?       Yes  No
- b. After any activity?       Yes  No
- c. Climbing (1) flight of stairs?       Yes  No
5. Do you have breathing problems that interfere with everyday activities?  Yes  No
6. Has anyone ever witnessed you stop breathing while you are sleeping?  Yes  No
7. Do you experience severe daytime fatigue?  Yes  No
8. Do you have morning headaches?  Yes  No
9. Do you see a pulmonologist (Lung Specialist)?  Yes  No
10. Have you had a sleep study?  Yes  No If yes, when: \_\_\_\_\_
11. Do you use CPAP or BiPAP?  Yes  No
12. The Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. 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 check the most appropriate number for each situation.
- 0 = No chance of dozing      2 = Moderate chance of dozing
- 1 = Slight chance of dozing      3 = High change of dozing
- 0    1    2    3   Sitting and reading.
- 0    1    2    3   Watching TV.
- 0    1    2    3   Sitting inactive in a public place (e.g. a theatre or meeting)
- 0    1    2    3   As a passenger in a car for an hour without a break.
- 0    1    2    3   Lying down to rest in the afternoon when circumstances permit.
- 0    1    2    3   Sitting and talking to someone.
- 0    1    2    3   In a car, while stopped for a few minutes in traffic.

Office use	Score	
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### BARIATRIC PRE-SCREENING ASSESSMENT

<b>Gastrointestinal &amp; Digestion</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Reflux Disease (GERD, heartburn)					
Hiatal Hernia					
Ulcers					
Gallbladder Disease					
Hepatitis					
Other Liver Disease					
Irritable Bowel Disease					
Inflammatory Bowel Disease (ex. Crohn's or Ulcerative Colitis)					
Diverticulitis					
Chronic Nausea/vomiting					
Bloody Stool					
Chronic Nausea/vomiting					
Bloody Stool					
Chronic Diarrhea					
Chronic Constipation					
Hemorrhoids					
Other _____					
<b>Cancer</b>					
Type:					
<b>Renal</b>					
Kidney Disease					
Urinary Incontinence					
Kidney Stones					
Frequent Urinary infections					
<b>Vascular Disease</b>					
Arterial Vascular disease					
Pulmonary Embolism (blood clot in lungs)					
Blood clots in legs (deep or superficial)					
Swelling in hands and feet					
Varicose Veins					
Leg Ulcers					
<b>Endocrine (Glands) &amp; Hormones</b>					
Diabetes Mellitus (sugar diabetes)					

**BARIATRIC PRE-SCREENING ASSESSMENT**

Neuropathy (numbness/tingling)					
Retinopathy (diabetic eye disease)					
Nephropathy (kidney problems)					
Male Impotence (erectile dysfunction)					
Hyperthyroid (too active)					
Hypothyroid (not active enough)					
Adrenal Gland (Cushing)					
Other _____					

13. Do you currently check your blood sugar at home?  Yes  No
14. Is your blood sugar controlled?  Yes  No
15. Do you currently, or have you ever used prednisone or steroids for any illness?  
 Yes  No If yes, explain: \_\_\_\_\_

<b>Nervous System</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Seizure Disorder					
Stroke (CVA)					
Migraine Headaches					
Other _____					
<b>Blood Disorders</b>					
Anemia					
Sickle Cell or Trait					
Bleeding or Clotting problems					

16. Do you have HIV or AIDS?  Yes  No

<b>Joints, Bones and Muscle</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Chronic Back Pain					
Chronic Neck Pain					
Osteoarthritis (DJD)					
Chronic Joint Pain					
Gout					
Fibromyalgia					
Autoimmune Disease (lupus, rheumatoid arthritis etc.)					

**BARIATRIC PRE-SCREENING ASSESSMENT**

Broken bones of face					
Broken bones of neck or back					
Other _____					

17. Are you able to walk on your own?     Yes    No

18. Do you use a:    cane?         walker?         wheelchair? (check all that apply)

<b>Emotional/Psychological</b>	<b>Yes</b>	<b>No</b>	<b>Year Diagnosed</b>	<b>Physician</b>	<b>Treatment</b>
Depression					
Bipolar Disorder					
Anxiety					
Schizophrenia					
Anorexia					
Bulimia					
Bingeing					
Physical, Sexual, emotional abuse					
Hospitalization for any above					
Other _____					

19. Do you currently see a psychologist or psychiatrist?     Yes    No

20. Do you have other medical disorders or symptoms that concern you?    Yes    No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**E. Social History**

1. Describe your current work status. (check all that apply)

- Full-time                       Part-time                       Unemployed                       Retired  
 Full-time (in-home)         Temporary                       Sick Leave

2. If employed what is your occupation: \_\_\_\_\_

3. Level of physical activity:    heavy    moderate    clerical    light    none

4. How much time can you take off work? \_\_\_\_\_

5. What is your marital status?

- Single                       Separated                       Widowed  
 Married                       Divorced                       Living in marriage – like relationship

## BARIATRIC PRE-SCREENING ASSESSMENT

6. Do you have children?       Yes    No      If yes, how many \_\_\_\_\_
7. Who currently lives in your household? \_\_\_\_\_
8. Who will be helping you when you get home? \_\_\_\_\_
9. Describe your racial/ethnic background.
- African American/Black                       Asian/Pacific Islander, specify \_\_\_\_\_
- White/Caucasian                                       American Indian/Native American/Alaskan Native
- Hispanic/Latino
- Other: \_\_\_\_\_
10. Education. Check the highest level of education obtained.
- Grade School                       Associate Degree (2yr)                       Doctoral Degree
- Some High School                       Some College, no degree
- High School Graduate                       Bachelor's Degree
- Vocational/Technical Training

### F. Substance Use History

1. Caffeine: Do you drink beverages that contain caffeine on a regular basis.    Yes    No  
If yes, how many drinks per day:

Coffee 6 oz.	Soda 12 oz.	Tea 6 oz	Hot Cocoa	Choc Milk	Other

2. Tobacco: Do you currently use tobacco:    Yes    No. If you currently do not use tobacco, have you ever used tobacco?    Yes    No. If yes to either, complete:

	Cigarettes	Cigars	Pipe	Chew/Snuff
What types				
Age at Start				
Years of regular use				
How much per day				
Age when quit				

## BARIATRIC PRE-SCREENING ASSESSMENT

3. Alcohol: Do you currently drink Alcohol?  Yes  No

	<b>Wine (4 oz)</b>	<b>Beer (12 oz)</b>	<b>Liquor (1 oz)</b>	<b>Mix Drink (1 oz)</b>
What types				
Years of regular use				
How much per month				
Age when quit				

4. Have you ever had a problem with alcohol dependence?  Yes  No. If yes, age when problem started \_\_\_\_\_.

5. Have you ever received treatment for alcohol dependence?  Yes  No

6. Other Drugs: Have you ever used illicit drugs?  Yes  No (ex. Marijuana, cocaine, heroine, amphetamine, etc). If yes:

What types				
Years of regular use				
How long age				
Age when quit				

7. Have you ever received treatment for illicit drug dependence?  Yes  No

### G. Family History

1. Are you part of a multiple birth (twin, triplet)?  Yes  No

2. Are you adopted?  Yes  No

3. Do you have knowledge of your biological family history?  Yes  No

	<b>Approx weight</b>	<b>Present Age</b>	<b>Age at Death</b>	<b>Cause of Death</b>	<b>Medical Problems</b>
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Sibling 1					
Sibling 2					
Sibling 3					

## BARIATRIC PRE-SCREENING ASSESSMENT

### H. Patients Physician History

#### Primary Care Physician

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

#### Other Physicians you see:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

### I. Weight/Diet History

1. What is your current height? \_\_\_\_\_ feet \_\_\_\_\_ inches

2. What is your current weight: \_\_\_\_\_ lbs?

3. What was your approximate weight in pounds at the following ages?

10 yrs \_\_\_\_\_ lbs.    18 yrs \_\_\_\_\_ lbs    25 yrs \_\_\_\_\_ lbs    30 yrs \_\_\_\_\_ lbs  
35 yrs \_\_\_\_\_ lbs    45 yrs \_\_\_\_\_ lbs    50 yrs \_\_\_\_\_ lbs    55 yrs \_\_\_\_\_ lbs

4. What is the most you ever weighed, (exclude pregnancies) \_\_\_\_\_ lbs \_\_\_\_\_ age

5. Have you ever been on a diet to lose weight?  Yes  No If yes, list all food or liquid diets you have tried. A sample list is provided, but there are others. If you haven't been on a physicians supervised diet, you are encouraged to participate in a program, starting as soon as possible. Many insurance carriers require this information; therefore it is **very important** to provide accurate and complete information.

Atkins Diet	Fit America	LA Weight Loss	Mayo Clinic	Richard Simmons
Cabbage Soup Diet	Grapefruit	Liquid Protein Diet	Metabolife	Slimfast
Calorie Count	Herbal Life	Low Calorie	Metrical	Stillman
Cambridge	High Protein	Low Carbohydrate	Nutri-system	Tops
Dean Ornish	Jenny Craig	Optifast/Medifast	Low fat	Weight Watchers
Personal Physician	Physicians Weight Loss		South Beach Diet	

## BARIATRIC PRE-SCREENING ASSESSMENT

Name of Diet	Start year	Length (Months)	Pounds Lost	Physician supervised?

Mark here if you have more than 12 diets. Add an attached sheet.

6. List all medications you have used for weight loss. A sample list is provided, but there are others. Many insurance carriers require this information; therefore it is **very important** to provide accurate and complete information. (Acutrim, Bontril, Didrex, Ionamin, Phentermine, Xenical, Adipen, Dexatrim, Fen/Phen, Meridia, Redux).

Medication & Dose	Start year	Length (Months)	Pounds Lost	Physician supervised?

7. List all behavioral treatments you have used for weight loss. A sample list is provided, but there are others. Many insurance carriers require this information; therefore it is **very important** to provide accurate and complete information. (Counseling, Hypnosis, John Hopkins, Duke Diet & Fitness Center, Inpatient therapy Mayo Clinic).

Behavioral/Combined Treatment	Start year	Length (Months)	Pounds Lost	Physician referral?

## BARIATRIC PRE-SCREENING ASSESSMENT

### UNDERSTANDING YOUR HEALTH INSURANCE AND WEIGHT LOSS SURGERY BENEFITS

Gastric Bypass surgery is an “elective” surgical procedure. Knowing how to correctly phrase your questions regarding coverage and benefits is the key to understanding what your plan will and will not cover.

On the back of this page, we have developed a tool to assist you in understanding your insurance benefits for obesity related surgeries. We ask that you use these questions as your guide when speaking with your insurance carrier as well as any other questions you personally have.

Additionally, we ask that you attach **a copy of your insurance card** (both front and back) to your packet. We will also be contacting your carrier with regard to your benefits.

*Special Phone Tips:* Some patients have encountered customer service representatives who will think that you are attempting to obtain authorization for your surgery as soon as you make your first phone call. Make it very clear to the customer service representative that you are not asking to be “pre-certified” or “pre-authorized” for Bariatric or lap band surgery. Explain that you are just calling to be educated on your plan benefits. If you still feel they are not answering your questions, politely ask to be connected to the supervisor.

*What to do if Morbid Obesity Related Surgery is listed as an Exclusion for your insurance plan?* From both the insurance carrier and your employer’s perspective, obesity surgery is not always viewed as the same type of surgical coverage for other surgeries, such as coronary artery bypass, fracture repair, appendectomy, or a mastectomy. In some insurance contracts, obesity surgical options are listed as plan exclusions.

If your plan states morbid obesity surgery is excluded, it does not mean someone is deciding whether the surgery for you is “medically necessary” or not. It simply means that your employer has elected not to have this service as part of the covered benefits of your insurance plan, similar to exclusions for cosmetic surgery, infertility services, and Lasik vision correction. If you encounter morbid obesity exclusions in your plan, take the time to meet with your Human Resources Department. Perhaps they are getting ready to change your plan benefits. Another possibility is to explore if your employer is willing to work with the carrier on a special consideration case for you.

# BARIATRIC PRE-SCREENING ASSESSMENT

## HEALTH INSURANCE INFORMATION QUESTIONNAIRE

**Please complete each question as thoroughly as possible.**

Insurance Company Name: \_\_\_\_\_

Member Customer Service Phone #: \_\_\_\_\_

Date Contacted: \_\_\_\_\_

Person spoke to: \_\_\_\_\_

1. Hello, my name is \_\_\_\_\_, and I would like to learn about my plan benefits with regard to morbid obesity surgeries, such as gastric bypass and lap banding. Does my policy cover services related to morbid obesity or is it an “exclusion” of my contract? *If it is an “exclusion”, the rest of the questions will not be applicable.*
2. Is a referral necessary to be seen by a Bariatric Surgeon?  Yes  No
3. Does my policy cover services for associated surgery clearances such as cardiac, pulmonary, and psychological evaluations and Pre-Admission Testing?  Yes  No
4. If benefits are allowed, what are the Medical Policy requirements? How can I review a copy +of them? (internet, can one be mailed to me).
  - Center of Excellence (COE) required?  Yes  No
  - BMI minimum is \_\_\_\_\_.
  - Diet history for \_\_\_\_\_ months within the past \_\_\_\_\_ months.
  - Exercise history for \_\_\_\_\_ months within the past \_\_\_\_\_ months.
  - Weight history for \_\_\_\_\_ years. (Do not confuse with a “diet” history).
  - Does my policy cover services for dietary/nutritional consults?  Yes  No
  - List any additional requirements separately and attach to form.

5. At what level does my policy pay for the following services (i.e.; 100%, 80%)?

<u>% of Payment</u>	<u>CPT CODE</u>	<u>DIAGNOSIS CODE</u>
_____	99244 Office Consultation	278.01
_____	43846 Gastric Bypass – Open	278.01
_____	43644 Gastric Bypass – Laparoscopy	278.01
_____	43770 Laparoscopy, gastric band	278.01

6. Do I have a deductible that must be satisfied? If so how much? \$\_\_\_\_\_

**BARIATRIC PRE-SCREENING ASSESSMENT**

- 7. What is my office visit co-pay amount? \_\_\_\_\_
- 8. Following surgery, periodic office visits are required after the 90 day global period and at a minimum annually. Are these office visits a covered benefit? Will they be covered when I am no longer diagnosed as morbidly obese?  Yes  No
- 9. I will also need periodic lab work done following my surgery, and at minimum, at least annually. Will these services be covered? Will they be covered when I am no longer diagnosed as morbidly obese?  Yes  No
- 11. Attach a copy of your insurance card (front and back) to this form:

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Patient Name (printed) Social Security Number

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Patient Signature Date

Return completed form to:  
Wake Surgical Specialists  
Charlotte Walton, Bariatric Navigator  
1101 Dresser Ct.  
Raleigh, NC 27609  
Phone: 919-876-2010  
Fax: 919-954-0555