New Bariatric Patient Instructions & Packet

Thank you for your recent attendance at our Bariatric Education Webinar. Please follow the next few steps closely.

1. Please fill out the "Bariatric New Patient Packet" (starting on page 2 of this letter).
2. Make a copy of your insurance card (both front and back are required).
3. Return the packet & insurance card to our office, via one of the following:
    - Fax to the Bariatric Clinic at 707-573-5360
    - Mail to Sutter Bariatric Clinic at 4729A Hoen Ave., Santa Rosa CA 95405
    - Drop off to the Bariatric Clinic in person

    Please do NOT send a screenshot, it may not print properly
4. Please allow 4-6 weeks to hear back from us. We review every patient individually and this process will take time. If you have not heard back from us in 6 weeks, please call our office at 707-577-7800 and leave us a message regarding the status of your packet.

While you're waiting to hear back from us you can:

- Contact your Primary Care Doctor to make sure they have sent us your referral.
- Go to www.healthystepsinfo.com to review Educational Videos.
- Start getting some regular exercise if you don't already. Go slow and don't get hurt.
- Start cutting down on fast foods, soda, sugar and excessive portions. Don't start any Fad diets.

We look forward to meeting you soon.

Warm Regards,

Bariatric Team

This Box is for Office Use Only: Seminar Attendance Date: _____/_____/_____

☐ Surgical ☐ Ready for consult w/ Surgeon ☐ Needs como

☐ OMS ☐ Ready for NP#1 ☐ Needs weight ☐ Needs BMI

☐ SM ☐ Needs carboxy ☐ Substance <2 yrs ☐ Restart

☐ needs attempt @ non-surgical wt loss

Carboxy info given to patient, ok to test 3 months out. Future date to test: _____

Carboxy reviewed on date of: _____ Reviewed by: _____ Ready? Yes

Bariatric Surgery Program New Patient Packet

Date: _____

Demographics (please print)

Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Best number to reach you:_____

Cell Phone: _____ Email: _____

PRIMARY Insurance (required to list ALL policies)

Insurance Co._____ **Subscriber Name: _____**

Policy: _____ **Subscriber DOB: _____**

Group #: _____

SECONDARY Insurance

Insurance Co._____ **Subscriber Name: _____**

Policy: _____ **Subscriber DOB: _____**

Group #: _____

Primary Care Physician (required)

Name: _____

Address: _____

_____

Phone: _____

Referring Physician (if different from PCP)

Name: _____

Address: _____

_____

Phone: _____

Health Questionnaire

Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** [ ] Male [ ] Female [ ] other: _____

Current Height: (required) _____ **Weight:** (required) _____ **BMI:** (use an internet search to calculate) _____

Medical History

Have you previously been a patient of the Sutter Santa Rosa Bariatric Clinic? [ ] Yes [ ] No

Have you ever had weight loss surgery ? [ ] Yes [ ] No

If yes, which surgery (circle)? **Date of bariatric surgery:** _____

[ ] Lap Band [ ] Band removal [ ] Sleeve Gastrectomy [ ] Roux-en-Y Gastric Bypass

[ ] Duodenal Switch [ ] gastric balloon [ ] other bariatric procedure _____

Do you have, or have you had, any of the following illnesses or symptoms? (check all that apply):

[ ] sleep apnea	[ ] morning headache	[ ] excess snoring	[ ] wake up short of breath
[ ] esophageal reflux	[ ] heartburn	[ ] hiatal hernia	[ ] chronic skin infections
[ ] diabetes	[ ] high blood pressure	[ ] heart disease	
[ ] arthritis	[ ] high cholesterol	[ ] blood clots in legs or lungs	
[ ] depression	[ ] asthma	[ ] urine incontinence	
[ ] sciatica	[ ] hernia	[ ] irregular menses	

Current Medications:

_____

_____

_____

Habits

Do you smoke tobacco/cannabis/vape? [ ] Yes [ ] No

If so how often? _____ **Years of use?** _____

If you have quit smoking, when? _____

Alcohol use (please circle): few drinks per day / few drinks per month / few drinks per year / none

Recreational Substance Use? _____

Download and fill out this form. Then fax to the Bariatric Clinic 707-573-5360
or Mail to Bariatric Clinic 4729A Hoen Ave. Santa Rosa, CA 95405

Name: _____

Weight History

What age did you become obese? _____ **What was your highest adult weight?** _____

What is your desired weight? _____ **How long have you been trying to lose weight?** _____

Which of the following program have you tried?

(check ALL boxes that apply) **(important for insurance requirements)**

[ ] Weight Watchers	[ ] Jenny Craig	[ ] Nutri-System	[ ] Diet Center	[ ] Atkins
[ ] Weight Mngt	[ ] Cambridge	[ ] Slimfast	[ ] Southbeach	[ ] Optifast
[ ] Medifast	[ ] Xenical	[ ] Meridia	[ ] Phentermine	[ ] Phen-fen
[ ] Redux	[ ] NONE			

Please list any other prior weight loss programs, diets, and medications you have tried:

_____

_____

Eating issues and problem habits (ex: portion control problems, emotional eating, sweets, late night snacking): _____

_____

_____

If you have any questions please write them down and bring them to your first consult. We look forward to meeting you.

_____

_____

_____

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