National Capital Region Medical

Bariatric Pre-Surgical Checklist 20180430

Please refer to the Walter Reed Bethesda (WRB) Bariatric Surgery website for additional information. If you are unable to find an answer to your question, please contact the WRB Bariatric Surgery clinic at (301) 295-4442.

Patient's Name: _____ DOB:_____

Best Phone Number: _____ DOD#: _____

Initial Behavioral Health Evaluation

This is the **first of two** required behavioral health appointments. You must schedule this appointment with the WRB Clinical Health Psychologist for Bariatric Surgery by calling the Integrated Referral Management and Appointing Center (IRMAC) at (855) 227-6331.

This patient completed the first evaluation within the required timeframe on: _____
(date)

See AHLTA note for one of following conclusions:

- ☐ Recognize and understand behavioral changes
- ☐ Patient will need a follow up appointment with me within _____ days for further evaluation. (Signature received when the requirement has been met)
- ☐ Patient requires additional appointments. SEE AHLTA NOTE

Clinical Health Psychologist's Signature: _____ Date: _____
(1^{st}, 2^{nd}, 3^{rd} visit)

Second Behavioral Health Evaluation

This is the **second of two** required behavioral health appointments. We will contact you to schedule this appointment because the IRMAC cannot schedule it for you. (This evaluation takes place AFTER YOU HAVE COMPLETED ALL OTHER AREAS OF THIS CHECKLIST.)

This patient completed the required pre-op evaluation on the following date: _____

See AHLTA note for one of following conclusions:

- ☐ There are no contraindications to surgery
- ☐ Patient will need to follow up within _____ days for further evaluation. (Signature received when the requirement has been met)
- ☐ Patient requires additional appointments. SEE AHLTA NOTE
- ☐ At this time, patient is not a good candidate for surgery. SEE AHLTA NOTE

Behavioral Health Provider's Signature: _____ Date: _____

Dietitian

Call the IRMAC at (855) 277-6331 to schedule your visits. You must see your dietitian every 4-6 weeks until you have surgery. **If you go more than 6 weeks without seeing your dietitian, you must restart your dietitian visits.**

This patient has completed the three primary nutrition pre-op appointments.

VISIT #1
Date: _____ Dietitian Name: _____

Starting weight _____ Has a food and exercise log. Yes / No

VISIT #2
Date: _____ Dietitian Name: _____

Total weight lost _____ Has a food and exercise log. Yes / No

VISIT #3
Date: _____ Dietitian Name: _____

Total weight lost _____ Has a food/exercise log. Yes / No

Over 3 visits, total pounds lost was: _____. Patient understands that we would like a minimum of ten pounds lost.

From a nutrition standpoint, this patient:

- ☐ is a good candidate for bariatric surgery due to a BMI of _____ kg/m², multiple previous unsuccessful diet attempts, and a demonstrated understanding of, and willingness to follow, the prescribed post-op diet.
- ☐ is not recommended for bariatric surgery for the following reason(s): (See AHLTA NOTE)
- ☐ understands that he/she must continue to see the Dietitian every 4-6 weeks.

Dietitian's Signature: _____ Date: _____

Exercise Physiologist:

(301) 295-4065, Bldg. 7, 3rd Floor (Liberty Bldg.), Rm. 3101

This patient has had the required pre-op evaluation on the following date: _____

- ☐ I recommend this patient for bariatric surgery. (See AHLTA Note)
- ☐ I do not recommend this patient for bariatric surgery. (See AHLTA Note)

Exercise Therapist's Signature: _____ Date: _____

Support Group

See list on website for locations. (You DO NOT need to register for Support Group meetings at WRB.) You will get credit for one visit per week.

This patient participated in a bariatric pre-op support group (five times) on the following dates:

#1 Date: _____ Location: _____

Facilitator's Signature: _____

#2 Date: _____ Location: _____

Facilitator's Signature: _____

#3 Date: _____ Location: _____

Facilitator's Signature: _____

#4 Date: _____ Location: _____

Facilitator's Signature: _____

#5 Date: _____ Location: _____

Facilitator's Signature: _____

Sleep Study:

Call (855) 227-6331 to schedule. If done outside of the MTF please bring in all documents. *This will not be signed until the study is complete*

- ☐ CPAP/BiPAP not recommended
- ☐ CPAP/BiPAP recommended

Setting: _____

Signature: _____ Date: _____

Please follow these directions if you have been issued a CPAP machine.

- ☐ You must wear your CPAP machine a minimal of 5 hours a night.
- ☐ When you come to the clinic, please have a print out of the last two weeks of your usage of the CPAP machine.
- ☐ Failure to present the requested information could delay your surgery date.
- ☐ Please contact the sleep center for any questions regarding your CPAP.

PCM*: I have ordered the following lab work and radiologic studies:** [complete below ***or make notations in AHLTA note.]

I will ensure that I address health maintenance issues with my PCM (e.g. mammograms and colonoscopies, as indicated).

- ☐ **Fasting Complete Metabolic Panel**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **Complete Blood Count**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **Vitamin D (calcidiol/25-hydroxy Vit D)**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____

continue on next page…

- ☐ **Lipid Panel**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **A1c**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **Zinc**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **Copper**
  - ☐ Results were WNL
  - ☐ The following results were abnormal: _____
- ☐ **TREATMENT PLAN for abnormal lab results:**

_____

_____

_____

****Your PCM will determine whether you need the following workup**

- ☐ **EKG** (for male age > 40, female age > 50, sedentary lifestyle) was done on _____
  - Results: _____
- ☐ **Cardiac Risk Stratification** (IAW ACC/ AHA guidelines): e.g. ECHO? _____

_____

Regarding EXERCISE…

How long has the patient been morbidly obese?_____

This patient:

- ☐ Has no restrictions for physical activity and has started a walking or other exercise program as required prior to bariatric surgery.
- ☐ Has the following restrictions for physical activity: _____

_____

These conditions are being optimally managed with the following: _____

_____

I recommend this patient for bariatric surgery and confirm that all health problems are being optimally medically managed in preparation for major surgery; a full H&P of systems with final letter of recommendation clearing this patient for surgery.

PCM's Signature: _____ Date: _____

Once you have completed all areas of this checklist, please contact the team via Secure Messaging or by calling the General Surgery clinic at (301) 295-4442 to request the second behavioral health referral.

Patient

Before making my pre-op appointment:
I certify that I have completed all the requirements on this checklist and any additional requirements made by the bariatric team. Failure to be compliant could and will result in delaying my surgical procedure. All areas have been signed and any documents from civilian providers are in my possession.

Patient's Signature: _____ Date: _____

Prepare Mentally and Emotionally:

- ☐ I understand the type of surgery I will be having. I have read all information given to me by the clinic staff.
- ☐ I know that I should abstain from drinking alcohol preoperatively, for 2 years post-operatively, and preferably avoid alcohol for the rest of my life
- ☐ I can commit to the changes in my lifestyle:
  - o New diet and exercise program
  - o Continuous follow up with my surgeon, dietitian, and exercise physiologist
- ☐ I have discussed bariatric surgery with my family and friends.
- ☐ I know where to get the information and support I need for this journey.
- ☐ _____

Initial Lifestyle Changes:

- ☐ I have started changing my diet to align with recommendations.
- ☐ **I have lost at least 10 lbs since I was referred by my PCM.**
- ☐ I have kept my food and exercise logs throughout this process.
- ☐ I have stopped smoking since enrolling in the program (if I had smoked).
- ☐ I have started an exercise program—walking as tolerated, swimming, etc.
- ☐ I understand that I must adhere to a 2 weeks or 4 weeks pre-op liquid protein diet.

Patient's Signature: _____ Date: _____

The REQUIRED 4-6 Week Monitored Dietitian Appointments:

Visit #4
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #5
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #6
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #7
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #8
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #9
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #10
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #11
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #12
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #13
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #14
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #15
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #16
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #17
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #18
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #19
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #20
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #21
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #22
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #23
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

Visit #24
Date: _____ Dietitian Name: _____
Total weight lost_____ Has a food/exercise log. Yes / No

If I have not completed the checklist in two years, I must start over!