Deaconess
WEIGHT LOSS SOLUTIONS

Welcome! We're thrilled that you're considering Deaconess Weight Loss Solutions as you embark on your transformative health journey. Our program offers tailored options, including both surgical and non-surgical pathways, empowering you to choose the path that feels right for you.

PROGRAM DETAILS

+ The Healthy Eating and Living Program (HELP):

- This non-surgical weight loss program offers numerous visit options tailored to your needs.
- At each visit, you'll have the opportunity to engage with a medical provider, dietitian, and exercise specialist.
- The program includes enriching online or Zoom nutrition classes, food and physical activity logging, and may involve medical testing (e.g., labs or sleep studies).
- Eligibility for medication is influenced by insurance coverage and personal medical history.

+ The Pre-Bariatric Surgery Program:

- A minimum 3-month commitment, with a minimum of 6 visits. Although insurance may require additional visits or more time if medical clearance is needed.
- Monthly sessions with a medical provider, dietitian, and exercise specialist will guide you through this process.
- This program will ask you to log food and exercise, complete nutrition classes, join group support meetings, undergo a psychological evaluation, and secure medical clearance for surgery, which may require referrals to specialists based on your medical conditions.

PROGRAM ELIGIBILITY REQUIREMENTS

Our weight loss program accepts patients 12 and up for our non-surgical program and patients 18 and older for our surgical program. For participants aged 12 to 17, a Body Mass Index (BMI) of 35 or greater is necessary. For individuals aged 18 and older, a BMI of 27 or higher is required to participate. Eligibility varies by program. Remember, eligibility for weight loss medications and surgery depends on your unique medical history, insurance, and specific requirements, so participation can differ.

NEXT STEPS

If you wish to learn about your bariatric benefits prior to your first visit, please reach out to your insurance company. Once the necessary steps are completed, we will connect with you to review your insurance coverage and schedule your initial appointment.

Your first appointment may last up to 3 hours. During this time, the provider will perform an initial exam, gather a comprehensive medical history, and present an overview of the program. The exercise specialist will conduct an In-Body exam and share exercise options, while the dietitian will review program requirements, like maintaining food logs and attending nutrition classes.

You deserve the time and dedication this program requires, and our team is here to support and uplift you every step of the way. If you have any questions about our programs, please don't hesitate to contact our office. We're here to cheer you on, and we can't wait to meet you at your upcoming appointment and support you in achieving your goals!

4219 Gateway Blvd., Ste. 2001, Newburgh IN 47630 | deaconess.com/weightloss | Phone: 812-450-7419 | Fax: 812-858-6843

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Welcome to Deaconess Weight Loss Solutions,

During each of your visits, you will be seen by a clinic provider, exercise specialist, and one of our dietitians. **Please review the important patient notification below:**

- Weight Loss Solutions is an outpatient department of Deaconess Hospital. Therefore, your insurance company will be billed for the following:
  1. A facility fee for the services provided
  2. A nutrition charge for the services of the dietitian
  3. A professional fee for services provided by our clinic provider

If you are participating in our surgical program, you will meet with one of our bariatric surgeons here in our office prior to your surgery. You will also be seen by the entire team again. **Please note the following notification regarding billing:**

- Your insurance company will be billed for:
  1. A facility fee for the services provided
  2. A nutrition charge for the services of the dietitian
  3. A professional fee from Evansville Surgical Associates for the services provided by one of our bariatric surgeons in our office.

Thank you for choosing us to care for you! We're committed to respecting your appointment times, though sometimes unexpected delays may happen. Your feedback is invaluable in helping us enhance the quality of care we provide. If you have any questions or concerns, don't hesitate to reach out to our office—we're here to help and look forward to assisting you!

Sincerely,
Deaconess Weight Loss Solutions Staff

My signature below indicates I have read and understand the information above.

Patient Signature _____ Date _____

PATIENT INFORMATION

Patient Name: _____

Street Address: _____

Mailing Address: _____

Phone Numbers: _____

Date of Birth: _____ Social Security #: _____

Email:_____

Sex: ❑ Male ❑ Female ❑ Other_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer:_____ Employer Phone:_____

Employer Address: _____

Spouse Name:_____ Spouse Phone: _____

Spouse Date of Birth:_____ Spouse Social Security #: _____

Spouse Employer:_____

Emergency Contact:_____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Secondary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Tertiary Insurance Company Name:_____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Please provide a copy of your insurance card(s), front and back, via fax, email or mail, along with the completion of the insurance information above.

MEDICAL HISTORY

Patient Name:_____Date of Birth: _____

Who is Your Primary Care Provider (PCP): _____

PCP Address:_____ PCP Phone: _____

Have you ever had a bariatric surgery or procedure?: ❑ Yes ❑ No

If yes, what kind?: ❑ Lap Band ❑ Sleeve ❑ Nissen ❑ Gastric Balloon ❑ Gastric Bypass

When was the Surgery?:_____

Where did You have the Surgery?:_____

Height:_____ Weight:_____ BMI:_____

Medical Condition your are **CURRENTLY** being treated:		
Condition:		Year Diagnosed:
❑	Acid Reflux (GERD)	
❑	Anxiety	
❑	Arthritis	
❑	Asthma	
❑	Back Pain	
❑	Bipolar Disorder	
❑	Cancer	
❑	Crohn's Disease	
❑	Ulcerative Colitis	
❑	COPD	
❑	Depression	
❑	Diabetes	
❑	Heart Attack	
❑	Heart Disease	
❑	High Blood Pressure	
❑	High Cholesterol	
❑	Joint Pain	
❑	Thyroid Cancer	
❑	Sleep Apnea ❑ C-Pap ❑ Bi-Pap	

Medications (Name/Dose/Frequency)

Medication Allergies	
Medicine	Reaction

Are you currently on dialysis?	❑ Yes	❑ No
Are you on a transplant list?	❑ Yes	❑ No
Do you have a single kidney?	❑ Yes	❑ No
Are you wheelchair bound?	❑ Yes	❑ No
Do you currently use oxygen?	❑ Yes	❑ No

Ever been treated for binge eating?	❑ Yes	❑ No
Ever had surgery outside of the USA?	❑ Yes	❑ No
Do you have a family history of thyroid cancer?	❑ Yes	❑ No
Ever had Pancreatitis?	❑ Yes	❑ No
Ever been diagnosed with MEN?	❑ Yes	❑ No

SOCIAL HISTORY

Do you drink alcohol? ❑ Yes ❑ No

If yes, how often do you drink? _____

If yes, how many drinks/day? _____

Did you drink heavily in the past? ❑ Yes ❑ No

If yes, do you still? _____

If you stopped drinking, when did you stop? _____

Do you currently use illegal drugs? ❑ Yes ❑ No

Have you used drugs in the past? ❑ Yes ❑ No

When did you start using? _____

When did you stop using? _____

What drugs/substances do you use?

_____

_____

Do you currently smoke? ❑ Yes ❑ No

If yes, how many packs/day? _____

When did you start smoking? _____

Are you willing to quit? ❑ Yes ❑ No

Did you previously smoke? ❑ Yes ❑ No

When did you quit? _____

Did you use e-cigarettes? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

How frequently? _____

SURGICAL AND HOSPITALIZATION HISTORY

Dates Type of Surgery or Reason for Hospitalization

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

If you are unaware of your family history, please document here: _____

Relative	Arthritis	Cancer	Diabetes	Heart Attack	Heart Disease	High Blood Pressure	Liver Disease	Lung Disease	Obesity	Sleep Apnea	Stroke	Age/Cause of Death
Mother												
Father												
Maternal Grandmother												
Maternal Grandfather												
Paternal Grandmother												
Paternal Grandfather												
Sibling 1												
Sibling 2												
Sibling 3												
Sibling 4												

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PROGRAM REQUIREMENTS

- If you need to cancel or reschedule your appointment, please call the office at least 24 If you need to cancel or reschedule your appointment, please call the office at least 24 hours in advance. If you miss your new patient appointment, you may have to wait to schedule a new one. For established patients, frequent late cancellations or no-shows may result in the termination of your care.
- Please note that weight loss medication and bariatric surgery are not guaranteed through this program. Eligibility will depend on your insurance coverage and personal medical history.
- Insurance coverage and requirements will vary by candidate, and the program requirements can differ as well.
- If your insurance approves bariatric services, some services may still not be covered. This may include, but is not limited to, nutrition visits with a dietitian, laboratory tests, psychological evaluations, and additional evaluations such as chest X-rays, EKGs, and sleep studies.
- For the bariatric surgery program, a minimum commitment of 3 months is required, including at least 6 visits and a psychological evaluation before surgery. Insurance may require additional visits or more time if medical clearance is necessary.
- During our program, participation in the following is required: monthly visits with registered dietitians and exercise specialists, completion of food and exercise logs, attendance in nutrition classes, and participation in at least one support group meeting.
- Patients must be drug-free for at least six months and remain drug-free throughout the program.
- Patients cannot have an uncontrolled psychiatric condition or a recent psychiatric hospitalization within six months prior to starting the program.
- Patients must also be nicotine-free for at least six weeks before surgery.

I acknowledge I have read and understand the information above, and my signature states I will comply with the program requirements. Failure to comply with program requirements may result in dismissal from the program.

Signature _____ Date _____

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Name _____ CSN (office use only) _____

Date of Birth _____ MRN (office use only) _____

NUTRITION ASSESSMENT QUESTIONNAIRE

Welcome to Deaconess Weight Loss Solutions. We look forward to supporting you in your journey to better health through weight loss. Please answer all of the following questions. If a question does not apply to you, answer with N/A.

GENERAL INFORMATION

Why are you seeking a weight loss program? How do you see this benefiting you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FOOD ALLERGIES AND INTOLERANCES

☐ Lactose/Dairy ☐ Shellfish ☐ Gluten ☐ Nuts

☐ Other: _____

_____

EATING ISSUES

☐ **YES** ☐ **NO** Wake up in the middle of the night and eat

☐ **YES** ☐ **NO** Frequently crave food throughout the day and night

☐ **YES** ☐ **NO** Frequently skips meals

☐ **YES** ☐ **NO** Feel that there are foods that you cannot live without

☐ **YES** ☐ **NO** Experience problems with chewing or swallowing

☐ **YES** ☐ **NO** Issues with portion control

If you checked yes on any of the above, please explain:

_____

_____

_____

_____

ENVIRONMENTAL ISSUES THAT AFFECT YOUR WEIGHT

☐ **YES** ☐ **NO** Occupational (working around food/no time for lunch)

☐ **YES** ☐ **NO** Sleep

☐ **YES** ☐ **NO** Travel

☐ **YES** ☐ **NO** Household (family/obligations/schedule)

☐ **YES** ☐ **NO** Shopping or cooking

☐ **YES** ☐ **NO** Meals eaten away from home

If you checked yes on any of the above, please explain:

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

I get my groceries at:

☐ Grocery Store ☐ Food Banks

☐ Convenience Store ☐ Farmer Market

☐ SNAP ☐ Other

☐ **YES** ☐ **NO** Do you have any issues purchasing nutritious foods?

☐ **YES** ☐ **NO** Do you have access to a kitchen?

ADDITIONAL QUESTIONS

How long have you been overweight or obese?

How much weight do you want to lose?

Who does the grocery shopping?

Who prepares the meals in your home?

On average, how many vegetables do you eat daily excluding peas, corn, and potatoes?

On average, how many fruits do you eat daily?

SUPPORT STRUCTURE

List the people who will be there to support you during your weight loss journey.

FOOD INTAKE HISTORY

Please list your food intake for the past 24 hours if it has been a typical day. If the past 24 hours have not been typical regarding meal patterns, then describe a typical day instead.

Breakfast **Time:_____**	**Lunch** **Time:_____**	**Dinner** **Time:_____**
Mid-Morning Snack **Time:_____**	**Mid-Afternoon Snack** **Time:_____**	**Bedtime Snack** **Time:_____**

DIET HISTORY

Type of Diet	Dates (Start and End)	Weight Lost	Weight Regained
Over-the-Counter Weight Loss Medication			
Prescription Weight Loss Medication			
Weight Loss Programs *(Weight Watchers, Noom, etc.)*			
Intermittent Fasting			
Nutritionist/Dietitian			
Therapy/Counseling			
Meal Replacement Program			
Weight Program Directed by a Doctor			
Restricted Diet Plan *(Keto, plant based, etc.)*			
Other			

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EPWORTH SLEEPINESS SCALE

Patient Name: _____

Today's Date:_____ Patient's Age:_____

Sex: ❑ Male ❑ Female ❑ Other_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? **This refers to your usual way of life in recent times.**

Even if you have done some of these things recently, please try to indicate how they **might** have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = You would **never** doze off.
1 = There is a **slight** chance of your dozing off.
2 = There is a **moderate** chance of you dozing off.
3 = There is a **high** chance of you dozing off.

Situation	**Chance of You Dozing Off**
Sitting and reading	_____
Watching TV	_____
Sitting inactive, in a public place (such as a theatre, a meeting, etc.)	_____
As a passenger in a car for one hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
YOUR TOTAL:	_____

Score:

0 to 10 Normal Range | 10 to 12 Borderline | 12 to 24 Abnormal Range