**AFTERCARE VISIT NOTE**: **NAME**: _____ **DATE OF BIRTH**: _____

Lapband Solutions

☐ **YELLOW ZONE** Hungry, thinking about food, and/or eating larger portions

☐ **GREEN ZONE** Small food portions (½-¾ cup), satisfied, eating ≤3 meals/day, satisfactory weight loss (or maintaining weight)

☐ **RED ZONE** Difficulty eating, reflux, regurgitation, night cough, heartburn, and/or consuming more liquids/softs than solids

**What is your meal portion size?** (Check box)
☐ ¼ cup ☐ ½ cup-¾ cup ☐ 1 cup ☐ 1½ cups ☐ ≥2 cups

**How long does it take you to eat?** (Check box)
☐ <15 minutes ☐ 15-30 minutes ☐ 30 minutes-1 hour ☐ >1hour

**How long after a meal do you feel hungry?** (Check box)
☐ 30 minutes-1 hour ☐ 1-2 hours ☐ 2-3 hours ☐ 3-4 hours ☐ 4-5 hours

**How often does food get stuck?** (Check box)
☐ Daily ☐ 2-3x/week ☐ 1x/week ☐ 1x/every 2 weeks ☐ Rarely ☐ Never

**Describe what you *TYPICALLY* eat for Breakfast, Lunch, and Dinner:**

**Breakfast**: _____

**Lunch**: _____

**Dinner**: _____

**# of snacks per day**: _____ **What type of snack(s) do you eat?** _____

**What type of liquids do you drink?** ☐ Water ☐ Soda (including Diet) ☐ Other _____

**When do you stop eating?** (Check box) ☐ Due to pain or discomfort ☐ Feeling of fullness ☐ I'm not full, but I stop myself ☐ Plate is empty ☐ Vomiting/regurgitation ☐ When satisfied

**Are you exercising?** ☐ No ☐ Yes, # of mins _____, # of times/week _____ **Type**: ☐ Gym ☐ Cardio ☐ Weights ☐ Walking ☐ Biking ☐ Hiking ☐ Trainer ☐ Other _____

**Informed Consent for Adjustable Gastric Band Adjustment**: I have an adjustable gastric band implant and wish to have the circumference of that system adjusted. I understand that the licensed medical professional providing this care may locate the access port for the adjustable gastric band using palpation (light pressure of the port area). Once the access port is located, the licensed medical professional will insert a non-coring needle into the access port to withdraw and/or inject saline (sterile salt water solution) into the adjustable gastric band. This will adjust the circumference of the adjustable gastric band.

**Potential Complications**

- **Addition of too much saline.** This may result in chest pain, chest tightness or heaviness, accompanied by nausea and vomiting and may occur immediately after an adjustment or even several days later. If this occurs, please contact us to remove some saline as soon as possible. I understand that this is not life threatening.
- **Gastroesophageal reflux** (return of the stomach's contents back up into the esophagus). Pharmacotherapy or the reduction of saline in the adjustable gastric band may be indicated to correct this.
- **Port infection.** This may require removal of the adjustable gastric band, replacement of the port, or antibiotic treatment.
- **Pain.** The non-coring needle used for this adjustment may cause brief, low-level discomfort.
- **Trauma to the skin.** Introduction of the non-coring needle into the access port may cause bleeding and/or bruising at the port site.
- **Port damage.** Introduction of the non-coring needle into the access port may, in rare instances, damage the port and necessitate its replacement.

**Potential Needle Contamination:** I have been advised that, for the purposes of this encounter, I am not required to submit a blood test for HIV, Hepatitis B, Hepatitis C, or any other communicable diseases. I understand that a blood test may be required if the non-coring needle used in my adjustment accidentally punctures any licensed medical professional or if any licensed medical professional is exposed to my mucous membranes, blood, or body fluids. Any such testing required will be performed in a manner which protects my privacy and will result in no financial cost to me.

**Patient Consent**: I hereby consent to undergo the adjustable gastric band adjustment as described above. I authorize the licensed medical professionals of Lapband Solutions to provide medical care and treatment for me and have provided them with all relevant information regarding my health history, review of systems, allergies, and all the medications I am currently taking (including prescriptions, over-the-counter medications, herbal remedies/supplements, and aspirin). I have further informed the licensed medical professionals of Lapband Solutions of any recreational drug or alcohol use. I acknowledge that it is important that I understand the medical care and treatment that I receive, and that I may ask my healthcare provider any questions that I may have regarding any aspect of my medical care and treatment. I am aware of and accept that there are no guarantees regarding the medical care and treatment being provided by the licensed medical professionals of Lapband Solutions.

_____ _____
**Patient Signature** **Date**

HT: _____ WT. _____ (Previous wt. _____; Date _____)

**VS**: ☐ See EMR **BMI** _____ **BP** _____ **HR** _____ **RR** _____ **O2 %** _____

**Review of Systems**: ☐ **WNL** (x̄ checked boxes below)

**General:** ☐ Fatigue ☐ Weight gain ☐ Weight loss
**Cardiovascular:** ☐ CP/discomfort ☐ Palpitations
**Respiratory:** ☐ Cough ☐ Night cough ☐ SOB with exertion ☐ Sleep disturbances
**Abdomen:** ☐ Heartburn ☐ Reflux ☐ Dysphagia ☐ Vomiting ☐ Regurgitation ☐ Abdominal pain
**Musculoskeletal:** ☐ Swelling ☐ Joint stiffness
**Psychological:** ☐ Anxiety ☐ Mood changes ☐ Depression
**Other:** _____

**Physical Exam:** ☐ **WNL**

**General:** Alert and oriented, normal LOC, NAD
**Resp:** Unlabored, chest symmetric with normal expansion
**Abdomen:** Soft, non-tender, non-distended, no organomegaly, no palpable masses, well-healed laparoscopic surgical scars
**Musculoskeletal:** Normal gait, fully mobile
**Psychological:** Judgement and insight good, mood/affect full range, cooperative with exam

**Other**:
**Cardiovascular:** ☐ RRR ☐ No murmurs, rubs, or gallups
**Respiratory:** ☐ CTA

**Notes**: Reviewed (Current medications, Medical/Family/Social/Surgical history)

Red Zone Sx: Onset _____ ☐ day(s) ☐ wk(s) ☐ month(s) ago
(Pt. has hx of red zone symptomatology at RV of _____ cc)

☐ **Denies** red zone sx (☐ x̄ dysphagia with large bites or bites eaten too quickly)

**Adjustment**: ☐ No adjustment performed

☐ Consent form reviewed and signed, palpation technique used to locate port, antiseptic skin prep applied, non-coring needle used to access the port, and the location within the port was confirmed in the usual fashion via aspiration. Disposition: Patient tolerated the procedure well and could drink water easily upon completion. Post-adjustment instructions provided.

☐ **NO** Lidocaine given ☐ 1.0cc of 1% Lidocaine administered

**Band Volume**:

Initial volume: _____ cc ☐ **TEV**

Volume added: _____ cc

Volume removed: _____ cc

Final volume: _____ cc

☐ Patient verbalizes understanding of increased risk of red zone symptomatology associated with aggressive adjustments

☐ Patient amenable to small amount of fluid removal only

☐ **Refusing Treatment Recommendation Form** completed

**Plan**: Post-adjustment instructions provided, liquids for _____ day(s), followed by soft foods for _____ day(s)

Return for follow-up visit in: _____ ☐ week(s) ☐ month(s), and PRN (minimum annually)

**Education**: Reviewed red zone symptoms and provided instructions to contact the office immediately if red zone symptoms develop (for Yellow/Green zone patients) or recur/persist (for Red zone patients) **and**:

☐ Exercise (☐ Incorporate exercise into routine ☐ ↑ exercise frequency ☐ Resume exercise)
☐ Diet (including food choices and calorie/protein intake; protein 1st followed by vegetables)
☐ ↓ consumption of refined carbohydrates
☐ Eating behaviors (dime-sized bites and wait 1 minute between bites)
☐ ↓ portion sizes to ½ cup-¾ cup
☐ Behavior modification discussed with pt. in detail
☐ Alternative meal/snack options
☐ Ensure adequate water intake daily (minimum of 64 ounces/2L)
☐ Air travel precautions provided (liquids only the day of travel, soft foods the next day)
☐ UGI recommended (annually) ☐ UGI ordered ☐ Pt. declines UGI @ this time
☐ Other: _____

**Healthcare Provider**: ☐ Dawn Morrison, ANP-BC _____ ☐ Maria Jaten, FNP-C _____ **Date**: _____