Lapband Solutions
& Medical Weight Management

Name: _____ **DOB**: _____ **Gender**: □ Female □ Male **Phone #**: _____

E-mail: _____ **Primary Care Provider**: _____

Past Medical History: *(Check all that apply in the boxes below)* **Bariatric Surgeon** (if applicable): _____

GENERAL /CONSTITUTIONAL
- □ Fatigue/Tiredness
- □ Insomnia
- □ Sleep Disturbances

EARS/NOSE/THROAT
- □ Allergic Rhinitis
- □ Difficulty Swallowing
- □ Hoarseness

CARDIOVASCULAR
- □ Chest Pain with exertion
- □ Congestive Heart Failure (CHF)
- □ DVT (Blood clot in the leg)
- □ Heart Disease
- □ Heart Murmur
- □ ***Heart Pounding/Palpitations***
- □ High Cholesterol
- □ Hypertension (↑ Blood Pressure)
- □ MI (Heart Attack)
- □ Pacemaker/Defibrillator
- □ Stroke
- □ Swelling of Legs (Edema)
- □ ***Tachycardia (↑ Heart rate)***

RESPIRATORY
- □ Asthma
- □ COPD/Emphysema
- □ Pulmonary Embolus (Blood clot in the lung)
- □ Shortness of breath with exertion
- □ Sleep Apnea

GASTROINTESTINAL
- □ ***Abdominal pain***
- □ ***Acid Reflux/GERD***
- □ Barrett's Esophagus
- □ Blood in Stool
- □ Crohn's Disease
- □ Fatty Liver *
- □ ***Gallbladder problems***
- □ Heartburn/Indigestion
- □ Hepatitis
- □ Irritable Bowel Syndrome
- □ ***Pancreatitis***
- □ Stomach Ulcers
- □ Ulcerative Colitis

GENITOURINARY
- □ Blood in Urine
- □ Kidney Disease
- □ Kidney Stones
- □ Urinary stress incontinence

MUSCULOSKELETAL
- □ Chronic Back Pain
- □ Degenerative Disc Disease
- □ Fibromyalgia
- □ Gout
- □ Joint pain
- □ Lupus
- □ Multiple Sclerosis
- □ Osteoarthritis
- □ Rheumatoid Arthritis

SKIN
- □ Eczema
- □ Psoriasis

NEUROLOGICAL
- □ Epilepsy (Seizure Disorder)
- □ Migraines

PSYCHIATRIC
- □ Anorexia
- □ Anxiety
- □ Binge Eating
- □ Bipolar Disorder
- □ Bulimia
- □ Depression
  - □ ***History of suicidal attempt***
  - □ ***Suicidal behavior***
  - □ ***Thoughts of self-harm***

ENDOCRINE
- □ ***Diabetic Retinopathy***
- □ Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- □ Polycystic Ovarian Syndrome
- □ Prediabetes *
- □ Thyroid Disorder
- □ ***Type I or Type II Diabetes***

HEMATOLOGIC
- □ Anemia
- □ Cancer
- □ HIV
- □ Medullary Thyroid Carcinoma

OTHER MEDICAL HISTORY
- □ _____
- □ _____
- □ _____

CURRENT MEDICATIONS:
□ NONE □ See Attached List

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY: *Lap-Band Placement (**Date**: _____) **Size**: □ APS (Small) □ APL (Large) □ Unknown □ Other _____

Surgery: _____ Date: _____ **Surgery**: _____ Date: _____

Surgery: _____ Date: _____ **Surgery**: _____ Date: _____

Surgery: _____ Date: _____ **Surgery**: _____ Date: _____

FAMILY HISTORY: □ Adopted □ No significant **paternal** family history (Healthy) □ No significant **maternal** family history (Healthy)

Mother's History: □ Unknown □ Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) □ Medullary Thyroid Carcinoma (MTC) □ Cancer □ Diabetes □ Heart Disease □ ↑Cholesterol □ Hypertension □ Stroke □ Obesity Other: _____

Father's History: □ Unknown □ Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) □ Medullary Thyroid Carcinoma (MTC) □ Cancer □ Diabetes □ Heart Disease □ ↑Cholesterol □ Hypertension □ Stroke □ Obesity Other: _____

DRUG ALLERGIES: □ ***NO KNOWN DRUG ALLERGIES*** □ PENICILLIN □ SULFA □ CODEINE □ IV CONTRAST DYE □ IODINE

OTHER: _____ □ LATEX □ SEASONAL □ ADHESIVE □ FOOD(S) _____

Patient Signature: _____ **Date**: _____

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

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

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☐ **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
☐ Hydration (minimum of 64 ounces/2L of water daily)
☐ 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**: _____

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PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the nurse practitioner including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the nurse practitioner, and the nurse practitioner's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the nurse practitioner to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Arizona statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Arizona Revised Statutes provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the nurse practitioner within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient's or Patient Representative's Initials: _____

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and I shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have been offered a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

By: _____ _____
Nurse Practitioner Signature **Date**

By: _____ _____
Patient's or Pt. Representative's Signature **Date**

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be filed in Patient's medical records.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

II. The information is to be **disclosed by**:

- □ **Care Physicians Arizona, P.C.**, 8360 E. Raintree Dr., Suite 120, Scottsdale, AZ 85260
- □ **Terry Simpson, MD FACS**, 9377 E Bell Rd #207, Scottsdale, AZ 85260; Fax#: (480)-500-5081
- □ **Weight Loss Institute of Arizona**, **LLC, DeBarros Surgical, LLC, Arizona Surgical Institute, LLC;** Fax#: (480)-446-7602 or (480)-446-9475

□ 1855 E Southern Ave., Tempe, AZ 85282	□ 8575 E Princess Dr., #215, Scottsdale, AZ 85255
□ 9305 W Thomas Rd., #480, Phoenix, AZ 85037	□ 16222 N 59th Ave., #D180, Glendale, AZ 85306
□ 4860 E. Baseline Rd., #105, Mesa AZ 85206	□ 6261 N La Cholla Blvd., #20, Tucson, AZ 85741

- □ **Lapband Solutions**, 10751 N. Frank Lloyd Wright Blvd., Suite B-106, Scottsdale, AZ 85259
- □ **Banner University Medical Center (Banner Surgical Associates;** Dr. Blackstone); Fax#: (602)-521-3046
- □ **Honor Health Bariatrics** (Dr. Marr, Dr. Swain; Formerly Dr. Blackstone); Fax#: (480)-391-3898
- □ **Other**: _____

And is to be **provided to**:

- □ **Lapband Solutions**, 10751 N. Frank Lloyd Wright Blvd., Suite B-106, Scottsdale, AZ 85259 ****Fax number: (618)-247-4494****
- □ **Agave Surgical Specialists** (Dr. Shawn Stevenson, Dr. Robertson, Dr. Leavitt), 1100 S. Dobson Rd., Suite 204, Chandler AZ 85286; Fax#: (623)-208-5075
- □ **Dr. Greg Robertson**, 5240 E. Knight Dr., Suite 118, Tucson, AZ 85712, Fax#: (520-)319-1454
- □ **Other**: _____

III. The purpose or need for this disclosure is: (Check appropriate box)

- □ Further Medical Care
- □ Personal Use
- □ Other _____

IV. The information to be disclosed from my health record: (Check appropriate box)

- □ Entire Record (including OP report and lap band adjustment history)
- □ Other: Only information related to (specify) _____

V. I understand that I may revoke this authorization in writing submitted at any time to the Custodian of Medical Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the Insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(Specify new date)

VI. I understand that Lapband Solutions will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) Research related or (2) Provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug abuse as defined in 42CFR Part 2, may be subject to re disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45-CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

PATIENT IDENTIFICATION: **NAME** (Last, First, MI):

ADDRESS:

CITY/STATE: **DATE OF BIRTH**:

_____

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE **DATE**
(If Representative, Print Name and Relationship to Patient)

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5USC 552a (i)(3)).