INFORMED CONSENT FOR LAPAROSCOPIC ADJUSTABLE GASTRIC BAND

It is very important to Venice Metabolic and Bariatric Surgery that you understand and consent to the treatment your doctor is providing for you and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

_____ _____
Patient's Initials or Authorized Representative Date

I have reviewed drawings of each of the available bariatric operations that diagrammatically show the main characteristics of each type of weight reduction operations, differences among operations, advantages, and disadvantages, of each procedure. I have had a chance to express to the surgeon my eating habits and behavior and my medical history and the surgeon has helped me to personally come to a conclusion as to the most appropriate operation for me, factoring in my eating, dietary, and medical background, and my future weight loss goals, pregnancy plans, and personal limits regarding acceptable meal size, bowel habits, and risk tolerance. The surgeon has counseled me regarding my decision, has made professional recommendations, and together we have agreed on the planned procedure as acceptable and appropriate.

_____ _____
Patient's Initials or Authorized Representative Date

I,_____, hereby authorize Dr._____and any associates or assistants the doctor deems appropriate, to perform gastric lap band surgery.

The doctor has explained to me the risks of obesity and the benefits of a gastric lap band procedure; however, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

Condition. I recognize that I am severely overweight with a weight of_____lbs. at_____ft._____ inches tall, and a BMI of_____. My surgeon or surgeons have clearly explained to me that this level of obesity has been shown to be unhealthy and that many scientific studies show that persons of this level of obesity are at increased risks of respiratory disease, high blood pressure, heart disease, high cholesterol, stroke, diabetes, arthritis, clotting problems, cancer and death as well as other serious and less serious medical illnesses.

Commitment. I am committed to long-term follow-up with my surgeon or surgeons and to make every effort to follow his/her directions to protect myself from these and other problems associated with Gastric Lap Band. I understand that to be effective, I need to make a life-long commitment to lifestyle changes, which may include, but are not limited to, dietary changes, an exercise program, and counseling. I understand that I will need to maintain proper nutrition, eat a balanced diet, and take vitamin and mineral supplements for the rest of my life. I will also be required to maintain follow-up medical care for my lifetime. Laboratory work will be required at least annually and perhaps more often, as directed by a physician.

Pre-operative Requirements. I have completed the Physician-Supervised Multidisciplinary Program, which included Dietary Therapy (a discussion of dietary history and a nutritional visit by a physician, dietitian or nutritional counselor), Activity, and Behavior Therapy and Support. Since the time of my initial

evaluation to the date of surgery, I have either maintained my weight or have not gained greater than 5 pounds.

Post-operative Requirements. I agree to participate in a post-surgical multidisciplinary program that includes diet, physical activity, and behavior modification.

Proposed Procedure. I understand that the procedure that my surgeon or surgeons have recommended for the treatment of my obesity is the gastric lap band procedure. My surgeon or surgeons have provided a detailed explanation of the proposed procedure. I have been strongly encouraged to make every effort to investigate and understand the details of the operation.

I understand the nature of a gastric lap band procedure will be done laparoscopically and entails the use of a fiberoptic endoscope along with special endoscopic instruments and staplers to facilitate in completing the procedure with smaller incisions than in an open approach.

I understand that it may be necessary to convert the procedure to an open technique if it is felt to be the best medical/surgical decision in the judgment of my surgeon (s). This conversion will result in a larger incision, which has been described to me by my surgeon.

I understand that my surgeon will initially attempt to perform this procedure laparoscopically. If the procedure cannot be done laparoscopically, I DO_____, DO NOT_____wish for my surgeon to proceed with an open procedure.

Contraindications. I understand that if my BMI is less than 40, the Lap Band procedure may not be right for me; however, if my BMI is less than 40 and I have other co-morbidities, I may be a candidate for this surgery, as explained by my physician.

Other Contraindications, ***include, but are not limited to***: current inflammatory disease or condition of the gastrointestinal tract such as ulcers, severe esophagitis, or Crohn's disease; current severe heart or lung disease which may make me a poor candidate for surgery; other diseases that make me a poor candidate for surgery; current health condition which cause bleeding in the esophagus or stomach, which might include esophageal or gastric varices (a dilated vein) or a congenital or acquired intestinal telangiectasia (dilation of a small blood vessel); current portal hypertension; an abnormal esophagus, stomach, or intestine whether congenital or acquired), such as a narrowed opening; prior intra-operative gastric injury such as a gastric perforation at or near the location of the intended band placement, current cirrhosis, chronic pancreatitis, pregnancy, addiction to alcohol or drugs; under the age of 18; an infection anywhere in my body or one that could contaminate the surgical area; chronic, long-term steroid treatment; inability to follow the dietary rules inherent with this procedure; allergy to materials in the device; autoimmune connective tissue disease of my own or family member, such as systemic lupus erythematosus or scleroderma, or symptoms of one of these types of disease. In addition, patients with a "sweet tooth" will not do well with the gastric lap band procedure or those that often drink milk shakes or other high-calorie liquids.

Risks/Possible Complications. The doctor has explained to me that there are risks and possible undesirable consequences associated with a Laparoscopic Gastric Band ***including, but not limited to***:

1. **Abscess**
2. **Adult Respiratory Distress Syndrome (ARDS)**
3. **Allergic reactions; band allergy**
4. **Anesthetic complications**
5. **Atelectasis**

6. **Band slippage, erosion, or deflation**

7. **Band removal**

8. **Bleeding, blood loss, blood transfusion and associated risks**

9. **Blood clots, including pulmonary embolus (blood clots migrating to the heart and lungs) and deep vein thrombosis (blood clots in the legs and/or arms)**

10. **Bile leak**

11. **Bowel obstruction**

12. **Cardiac rhythm disturbances**

13. **Cardiospasm (an obstruction of passage of food through the bottom of esophagus)**

14. **Cholecystitis (gall stones)**

15. **Complications in subsequent pregnancy (no pregnancy should occur within the first year after surgery)**

16. **Congestive heart failure**

17. **Constipation or abnormal stools**

18. **Dehydration**

19. **Dehiscence or evisceration**

20. **Depression**

21. **Diarrhea**

22. **Dumping syndrome**

23. **Death**

24. **Dislocation/displacement of injection port**

25. **Dysphagia**

26. **Encephalopathy**

27. **Esophageal dilatation, pouch or small bowel motility disorders**

28. **Esophagitis**

29. **Flatulence (gas)**

30. **Gastritis**

31. **Gout**

32. **Hematemesis (vomiting of blood)**

33. **Hernias, incisional and internal (including the port sites for laparoscopic access)**

34. **Inadequate or excessive weight loss**

35. **Infections at the surgical site, either superficial or deep including port sites for laparoscopic access. These could lead to wound breakdowns and hernia formation.**

36. **Injury to the bowels, blood vessels, bile duct, and other organs**

37. **Injury to adjacent structures, including the spleen, liver, diaphragm, pancreas and colon**

38. **Intestinal leak or port leak**

39. **Kidney failure**

40. **Kidney stones**

41. **Loss of bodily function (including from stroke, heart attack, or limb loss)**

42. **Myocardial infarction (heart attack)**

43. **Nausea and/or vomiting**

44. **Need for and side effects of drugs**

45. **Organ failure**

46. **Perforations (leaks) of the stomach or intestine causing peritonitis, subphrenic abscess or enteroenteric or enterocutaneous fistulas**

49. **Pleural effusions (fluid around the lungs)**

50. **Pneumonia**

51. **Possible removal of the spleen**

52. **Pressure sores**

53. **Pulmonary edema (fluid in the lungs)**

54. **Possibility of a reoperation**

55. **Pouch dilatation or twisting**

56. **Reflux or regurgitation**

57. **Serious intra-abdominal infection such as sepsis or peritonitis**

58. **Skin breakdown**

59. **Small bowel obstructions**

60. **Stoma stenosis or obstruction**

61. **Stomach slippage**

62. **Stroke**

63. **Systemic Inflammatory Response Syndrome (SIRS)**

64. **Ulcer formation (marginal ulcer, esophageal, or in distal stomach)**

65. **Urinary tract infections**

66. **Weight regain, slow weight loss, or no weight loss**

67. **Wound infection**

a. Nutritional complications ***include but are not limited to:***

1. **Protein malnutrition**

2. **Vitamin deficiencies, including B12, B1, B6, folate and fat soluble vitamins A,D,E,K**

3. **Mineral deficiencies, including calcium, magnesium, iron, zinc, copper, and other**

4. **Uncorrected deficiencies can lead to anemia, neuro-psychiatric disorders and nerve damage, that is, neuropathy**

b. Psychiatric complications ***include but are not limited to:***

1. **Depression**

2. **Bulimia**

3. **Anorexia**

4. **Dysfunctional social problem**

c. Other complications ***include but are not limited to:***

1. **Adverse outcomes may be precipitated by smoking**

2. **Bloating**

3. **Cramping**

4. **Development of gallstones**

5. **Low blood sugar, especially with improper eating habits**

6. **Vomiting, inability to eat certain foods, especially with improper eating habits or poor dentition**

7. **Loose skin**

8. **Intertriginous dermatitis due to loose skin**

9. **Hair loss (alopecia)**

10. **Anemia**

11. **Bone disease**

12. **Low blood pressure**

13. **Cold intolerance**

14. **Fatty liver disease or non-alcoholic liver disease (NALF)**

15. **Progression of pre-existing NALF or cirrhosis**

16. **Vitamin deficiencies some of which may already exist before surgery**

17. **Diminished alcohol tolerance**

d. Pregnancy complications were explained as follows:

1. **Pregnancy should be deferred for 12 to 18 months after surgery or until the weight loss is stabilized**

2. **Vitamin supplementation during the pregnancy should be continued**

3. **Extra folic acid should be taken for planned pregnancies**

4. **Obese mothers have children with a higher incidence of neural tube defects and congenital heart defects**

5. **Pregnancy should be discussed with an obstetrician**

6. **Special nutritional needs may be indicated or necessary**

7. **Secure forms of birth control should be used in the first year after surgery**

8. **Fertility may improve with weight loss**

Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize.

I also understand that some or all of the complications listed on this form and also explained to me may exist whether the surgery is performed or not, in that gastric lap band surgery is not the only cause of these complications.

Alternative Procedures. In permitting my doctor to perform this procedure, I understand that unforeseen conditions may necessitate change or extension of the original procedure(s), including completing the operation by way of the conventional open surgical approach, or a different procedure from what was explained to me. I therefore authorize and request that the above-named physician, his assistants or designees to perform such procedure(s) as may be necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternative(s) to the procedure(s), as well as the risks to the alternatives, have been explained to me. These alternatives include, ***but are not limited to***, open gastric band, gastric bypass, vertical banded gastroplasty, various diet exercise and drug treatments, or no surgery at all.

I understand that my surgeon will initially attempt to perform this procedure laparoscopically. If the procedure cannot be done laparoscopically, I DO_____, DO NOT_____wish for my surgeon to proceed with an open procedure.

I hereby authorize the disposal of removed tissues resulting from the procedure(s) authorized above.

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

_____/_____/_____ _____

Date Time Signature of Patient or Authorized Rep. Relationship of Authorized Rep.

- ❑ The Patient/Authorized Representative has read this form or had it read to him/her.
- ❑ The Patient/Authorized Representative states that he/she understands this information.
- ❑ The Patient/Authorized Representative has no further questions.

_____ _____ _____

Date Time Signature of Witness

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

_____ _____ _____

Date Time Signature of Physician

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____

(Fill in name of Interpreter and Title or Relationship to Patient)

_____ _____ _____

Signature (Individual Providing Assistance) Date Time

Patient Responsibilities

The purpose of this document is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.

Instructions: Please read each paragraph, and once you agree to the contents of the paragraph, please write your initials on the line next to the paragraph. If you have any questions as to the meaning of any paragraph, please ask for physician to explain it to you.

_____I understand that trust and confidence is necessary in a physician-patient relationship

_____I understand that if I do not follow through with all of the terms of this documents that my physician may refuse to perform the procedure or may discharge me as a patient from the practice at any time.

_____I understand that my care and treatment may include use of prescription drugs such as narcotics for pain control. I agree that if I misuse the drugs prescribed for me my physician may terminate my care and treatment. Misuse includes altering prescriptions, taking other than the prescribed dosage, or using fraudulent or illegal means to obtain drugs.

_____I will fully communicate to my physician any concerns and will also communicate to my physician or other applicable healthcare provider any suspected complications after my surgery.

_____I agree to comply with the pre- and post-surgery protocols, which includes attending support group programs, following the diet(s) provided to me, and behavior modification.

_____I agree to keep my follow up appointments as recommended by my surgeon and/or primary care physician.

_____I agree to take my vitamins, calcium and other supplements for life as directed by my surgeon and/or primary care physician.

_____I agree to have blood work done for life on an at least annual basis.

_____I agree to see my surgeon and family physician as directed.

_____Any medical condition that exists or may develop, not in direct relationship to the bariatric surgery, must be treated by my primary care physician (and/or appropriate specialty physician), and I agree to coordinate my care with my surgeon. I understand that my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

_____I understand that successful long term weight loss is dependent on following the principles and guidelines of my surgeon's bariatric program.

_____I verify that I have completed a medical history questionnaire and that to the best of my knowledge it is true and correct.

I have read this form and discussed any questions that I have with my surgeon.

Patient Name_____ (printed)

Patient Signature_____Date_____

WITNESS:

- □ The Patient/Authorized Representative has read the form or had it read to him/her
- □ The Patient/Authorized Representative expresses understanding of the form
- □ The Patient/Authorized Representative has no questions

Witness Name_____ (printed)

Witness Signature Date

USE OF INTERPRETER OR SPECIAL ASSISTANCE An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign Language (specify)

_____ Sign Language

_____ Patient is blind, form read to patient

_____ Other (specify)_____

Interpretation provided by_____

Fill in name of interpreter and title or relationship to patient

Signature (Individual providing assistance) Date

GUIDELINES FOR YOUR BARIATRIC SURGERY

NSAIDS (Non-Steroidal Anti-Inflammatory)

NSAIDS have been linked to causing ulcers following weight loss surgery and should be avoided. Examples include: Advil, Aleve, Anaprox, Ansaid, Aspirin (Excedrin, Bufferin), Beta, Cataflam, Celebrex, Clinoril, Daypro, Feldene, Ibuprofen, Indocin SR, Lodine, Lodine XL, Motrin, Naprelan, Naprosyn, Orudis, Relafen, Tolectin, Toradol, Vioxx, Voltaren.

Use of any of these medications must be discussed and approved by your surgeon.

STEROIDS

Oral Steroids are not permitted after surgery. Immunomodulators such as methotrexate, embrel, and humera must be discussed and approved by your surgeon. Avoid the use of intravenous steroids under any circumstances.

DIURETICS (WATER PILLS)

Use caution when using diuretics (water pills). This is especially important in the early postoperative period when it can be more difficult to get in enough fluid. Please discuss with your surgeon.

TRAVEL

Long car trips, prolonged seating, and airline travel must be discussed with your surgeon if they occur within 30 days of surgery. These activities may put you at risk of developing blood clots.

HERBAL SUPPLEMENTS

Do not use fish oil, garlic, ginseng, ginkgo, or other herbal supplements within 2 weeks of surgery. They may all cause increased bleeding.

PREGNANCY

Forms of birth control such as oral pills, patches, injections, implants or vaginal rings need to be stopped one month before surgery and should not be resumed until one month after surgery. Use extreme caution during this time and use reliable method of birth control to prevent pregnancy. The use of condoms, although not 100% effective, is the most reliable. A diaphragm is acceptable, but must be continuously adjusted with weight loss.

Patient Signature *Date*

Witness Signature *Date*

Smoking, Bariatric Surgery and YOU!

If you smoke, your bariatric surgeon will require you to stop smoking at least 8 weeks before your surgery. This is because patients who smoke are at a higher risk of having surgical complications, anesthesia complications and are more likely to develop pneumonia after surgery. Smoking also contradicts the purpose of bariatric surgery, which is about improving your overall health and quality of life.

We understand there are a number of reasons why it is difficult to stop smoking. Nicotine is the drug in tobacco products that causes dependence. Patients who smoke, even in moderation, are dependent on nicotine. Nicotine dependence is the most common form of chemical dependence in the United States. There are many health risks associated with smoking. Bariatric patients who have smoked for a long period of time fear gaining extra pounds once they quit smoking. We also understand that this is a time of stress because you are busy preparing for your upcoming surgery and anticipating the lifelong changes that follow. Regardless, we understand the effort involved but believe the risks of smoking are great and the benefits of smoking cessation far outweigh these inconveniences.

We want to help you reach your goals. So here are some tips:

First let's talk about why patients gain weight after they quit smoking:

1) Changes in metabolic rate
   Nicotine raises the metabolic rate, this temporarily slows after smoking cessation. Your body will burn off fewer calories, which causes the tendency to gain weight in some patients.
2) Changes in eating habits
   Patients are more inclined to eat sweet or fatty foods to eat more because food simply tastes better as taste buds reactivate.
3) Oral cravings
   Many patients who have recently stopped smoking report that they miss the feeling of having something in their mouth. This could lead to snacking or mindless eating.

Take advantage of the 8 weeks before surgery to make adjustments to your eating and exercise habits:

- Discuss options for weight management with our dietician
- Discuss STOPSMOKING behavioral counseling with your counselor
- Discuss pharmaceutical options with your doctor
- Get active!

We encourage you to access, download and review the American Cancer Society *Guide to Quit Smoking* and *Quit Smoking Tips* by googling:

- ACS Guide to Quitting Smoking
- ACS Quit Smoking Tips

Patient's Signature

Alcohol Consumption after Gastric Bypass

Does Gastric Bypass Alter Alcohol Metabolism?
Surgery for Obesity and Related Diseases. Volume 3. Issue 5. Pages 543-548 J Hagedom. B. Encamacion. G. Brat. J. Morton.

Gastric bypass surgery is the most efficient means of treating morbid obesity in individuals with a body mass index (BMI) over 40kg m. This operation has become the most commonly performed procedure in bariatric surgery. All surgeries, including elective bariatric surgery procedures, carry risks.

One particular risk associated after gastric bypass surgery is altered alcohol metabolism. IN a study of 36 subjects, 17 control and 19 post-gastric bypass subjects that consumed 5 oz. of red wine, the gastric bypass patients had a peak alcohol breath level of 0.08% and the controls had a level of 0.05%. The gastric bypass group reached this level after an average of 72 minutes. The conclusion is that gastric bypass patients may have an increased sensitivity to the effects of alcohol; therefore, caution should be exercised in the use of alcohol after a gastric bypass procedure.

The purpose of this document is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.

I_____ have read and understand that alcohol metabolism after gastric bypass surgery may be altered and that my use of alcohol is voluntary. I understand that alcohol can be addictive and destructive to my health, and may lead to accidents of unintended consequences. I have been fully informed of my increased relative risk and consequences of consuming alcohol after a gastric bypass.

_____

Patient's Signature

Witness Signature

Date

Patient Contract

Understanding pregnancy, fertility and bariatric surgery

This patient contact is provided to ensure that you fully understand that women of childbearing age who have had bariatric surgery must take special precautions in avoiding pregnancy for a designated period of time after weight loss. Weight loss due to bariatric surgery often increases fertility in those whom have had difficulty conceiving in the past. With that in mind, please complete the following:

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statement:

_____1. I understand that one of the goals of the Patient Contract is to help my bariatric team Members understand that I commit to avoid pregnancy until discussed and cleared with my surgeon and obstetrician.

_____2. I understand and agree that pregnancy should not be attempted until weight loss and nutritional intake have stabilized.

_____3. As a woman of childbearing age who seeks bariatric surgery, I commit to using two reliable birth control methods during the period of rapid weight loss.

_____4. I understand that maternal malnutrition may impair normal fetal development.

_____5. When I become pregnant, I understand the importance of prenatal vitamins and other supplements and agree to take the prescribed amounts prior to and for the entire pregnancy as recommended by my dietician or obstetrician.

_____6. I expect to delay pregnancy for at *kast 18* months after surgery

_____7. I agree to discuss my procedure, the need for birth control, and my commitment to avoid pregnancy with my significant family members.

_____8. When I become pregnant, I can expect that my surgeon and obstetrician will order special testing and treatments that could result in additional costs.

_____9. I understand that I must stop all birth control (oral pills, patches, injections, implants, vaginal rings) one month before surgery and will not resume them until one month after surgery. Use extreme caution during this time and use reliable method of birth control to prevent pregnancy. The use of condoms, although not 100% effective, is the most reliable. A diaphragm is acceptable, but must be continuously adjusted with weight loss.

Date Time Signature of patient or authorized representative relationship

WITNESS:

□ The patient/Authorized Representative has read the entire form or has had it read to him/her
□ The Patient/Authorized Representative express understanding of the form
□ The Patient/Authorized Representative has no further questions

Venice Metabolic and Bariatric Surgery

Pain Medication Policy

We at Venice Metabolic and Bariatric Surgery advocate for our patients as strongly and in as many ways as possible. We know that wounds from surgery can be painful.

The majority of bariatric surgery patients will use narcotic pain medications post operatively, for a very limited time. Those medications may include but are not limited to: Percocet, Oxycodone, Dilaudid tablets, Vicodin, Codeine and Ultram.

It is our policy to limit post-operative pain medication to those prescribed at the time of discharge. Florida State Law prohibits prescribing narcotic pain medication over the phone. Our practice is not intended to manage a patient's pain on a long-term basis, and we refer patients in need of long-term pain management or pain management needed that does not arise from our procedure to a pain management specialist. THERE CAN BE NO EXCEPTIONS TO THIS POLICY.

Furthermore, you should be aware of Florida' s_Prescription Monitoring Program that tracks pain medication prescriptions written by physicians AND prescriptions filled. Florida implemented this program as part of its efforts to impact prescription pain medication abuse, and is for your protection. Venice Metabolic and Bariatric Surgery_is committed to compliance with these requirements.

In the event that a patient has had issues with severe pain previously associated with medical care, we recommend evaluation by a pain specialist PRIOR to any planned procedure. We would be happy to refer you to a local specialist physician should you be interested in this option. For those patients who are already under the care of a pain specialist, we recommend that you contact them prior to surgery to inform them of the planned procedure. We welcome recommendations from your specialist for *in hospital* care and will defer to your specialist on your best method of pain control post operatively. We do request that they send us instructions for your specific care, and that they prescribe your medications after discharge to avoid confusion.

Sincerely,

The Team at Venice Metabolic and Bariatric Surgery

Patient Signature and Date

Spousal Agreement

I,_____ , am presently married to_____
("Patient"). I understand that Patient wishes to undergo bariatric surgery. I have been actively involved in and fully support Patient's decision to undergo bariatric surgery.

- I have been fully informed of the nature of bariatric surgery.
- I fully understand that the surgery which Patient will undergo will require a lifelong commitment on the part of the Patient, including changes in diet and behavior modification.
- I also understand that the bariatric surgery involves dangers and risks including, but not limited to, post-operative infection, leaks, death, depression, emotional changes and other physical and psychological changes all of which I fully understand.
- I understand that as a result of this surgery, Patient may lose a significant amount of weight, changing his/her appearance.

It is with my full knowledge and consent that my spouse, the Patient, undergo bariatric surgery.

Dated at_____ this_____day of_____ ,—

Spouse signature:_____

Printed Name:_____

Witness Signature:_____

Printed Name:

Can also be used by Significant Other

Advocate Support Agreement

Please attest to the following statements by indicating agreement with your initials to the left of each statement and your signature below. We encourage you to ask any questions or discuss any concerns at this time.

_____ I understand that_____(Patient) wishes to undergo bariatric surgery.

_____ I have been fully informed of the nature of bariatric surgery.

_____ I have been actively involved in and fully support Patient's autonomous decision to undergo bariatric surgery.

_____ I fully understand that bariatric surgery involves dangers and risks including, but not limited to, post-operative infection, leaks, death, depression and physical and psychological and emotional changes that are listed on the informed consent, which I have read and understand fully.

_____ I understand that as a result of this surgery, Patient may lose a significant amount of Weight, changing his/her appearance.

_____ I fully understand that the surgery which Patient will undergo requires a lifelong commitment to behavioral changes which could include changes in eating habits, emotional coping skills and more.

_____ I have no further questions or concerns to discuss at this time. However, if I do have questions in the future, I have been encouraged by the bariatric team to ask.

It is with my full knowledge and agreement that Patient undergo bariatric surgery.

Advocate Signature_____

Printed Name_____

Witness Signature_____

Printed Name

Patient Contract
Vitamin and Protein Supplements

_____1. I understand that Roux-en-Y Gastric Bypass is both malabsorptive and restrictive; if I do not take the
recommended vitamin/mineral supplements, I may develop vitamin/mineral deficiencies.

_____2. I understand that my bariatric surgery team may ask me to keep a food journal/diary to help assess
nutritional problems, protein/vitamin intake or disordered eating behavior.

_____3. I can expect nutritional lab work done at least annually for the rest of my life, and it is my
responsibility to have this done as directed.

_____4. I understand the importance of a balanced diet including protein which promotes satiety (fullness) and
protects muscle mass during active weight loss.

_____5. I agree to take the recommended vitamin/mineral supplementation regimen recommended by my
team which typically includes: multivitamin, vitamin B12, calcium citrate, vitamin D, (and others as indicated by deficiencies found on my lab work).

_____6. I agree to work on eating habits/behaviors before surgery to optimize my weight loss and nutrition,
and will need to pay attention to my eating habits/behaviors for life.

_____7. If my lab work shows vitamin/mineral deficiencies before surgery, I may need to repeat these levels
before having surgery to optimize my health.

_____8. It is my responsibility to ask questions when I am uncertain about vitamins and

protein supplements.

_____9. I understand that if I fail to accept my responsibility for care as directed by the team, I could be terminated from their care.

- □ The Patient/Authorized Representative has read the entire form or had it read to him/her.
- □ The Patient/Authorized Representative has express understanding of this form.
- □ The Patient/Authorized Representative has no further questions.

Date	Time	Signature of Patient or Authorized Representative

Date	Time	Witness Signature

Vitamin and Protein Supplements Test

True False
True False
True False
True False
True False
True False
True False
True False
True False
True False
True False
True False

1. Roux-en-Y Gastric Bypass is both malabsorptive and restrictive.
2. Malabsorption is not typically a problem after laparoscopic adjustable band.
3. I understand that I am expected to keep food diaries because they help assess nutritional problems, protein/vitamin intake or disordered eating behaviors.
4. I can expect lab work done at least annually for the rest of my life, and it is my responsibility to have this done as directed.
5. I understand the importance of protein to health and recognize poor protein intake could lead to hair loss.
6. The malabsorptive and restrictive nature of gastric bypass predisposes me to protein and vitamin deficiencies.
7. I agree to take B-complex and chewable calcium as directed daily.
8. Attention to protein and vitamin supplement begins before surgery and continues for life.
9. I agree to take thiamine supplements along with a quality multivitamin each day as directed by my healthcare team.
10. Some patients are protein/vitamin challenged before surgery, and therefore dietary education and nutritional changes must occur even before surgery.
11. It is my responsibility to ask questions when I am uncertain about vitamins and protein supplements.
12. I understand that if I fail to accept my responsibility for care as directed by the team, I could be terminated from care.

Date Time Signature of Patient or Authorized Representative

- □ The Patient/Authorized Representative has read the entire form or had it read to him/her.
- □ The Patient/Authorized Representative has express understanding of this form.
- □ The Patient/Authorized Representative has no further questions.

Date *Time* *Witness Signature*