

Shelby Baptist Bariatric Program

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Request & Consent for Bariatric Surgery

I, _____, request that Dr. _____ (check here _____ if no surgeon preference) and his/her associates at Cahaba Valley Surgical Group, PC operate on me for obesity. I have read the information on the website, or in the packet provided, regarding the Bariatric Program including overview, risks, benefits and alternatives. I am interested in proceeding with a consultation and surgery.

Please check which procedure below: (Complete the applicable self-test after reading all information).

Gastric Bypass

I understand the operation will reduce the size of my stomach such that it will only hold _____ tablespoons. This will be accomplished by partitioning the stomach with a stapler. I further understand the lower portion of my stomach and first portion of the intestine will be bypassed, and a new connection between the stomach and intestine will be created. The portion of the intestine carrying the digestive enzymes will be connected to the intestine emptying the stomach about six feet downstream. This results in certain potential vitamin and mineral deficiencies that will require lifelong supplementation. I agree to removal of my gall bladder at the discretion of the surgeon. I know there are significant risks including (list at least 4):

1. _____ 2. _____ 3. _____ 4. _____

The risk of death from the operation is estimated at _____ in 100, and I may fail to lose weight despite the operation. A successful operation is one in which a patient loses _____% of their **excess** body weight, and therefore I may still be obese even with an excellent result. Although I will likely be able to try most foods, I should avoid sweets and calorie dense foods. Vomiting is a common complaint after this operation.

Laparoscopic Adjustable Gastric Band Surgery

I understand that this procedure entails my surgeon implanting a device around the upper portion of my stomach, restricting the size of the stomach opening. This procedure will require dietary and behavior modification to accommodate the size of the stomach opening. This procedure will also require me to make periodic / ongoing visits to my surgeon to undergo band adjustments, which involve accessing the port with a needle inserted through the skin. I also understand that there are risks associated with this procedure, and I will read all materials and attend all educational sessions recommended by my physician.

List 4 possible adverse events that can occur after adjustable gastric band placement: 1. _____ 2. _____
3. _____ 4. _____

Sleeve Gastrectomy

I understand that this procedure entails my surgeon sectioning off a portion of my stomach using a stapling device, removing that portion, and leaving behind a banana-shaped smaller stomach. This procedure is restrictive only and does not include by-passing portions of the intestines. This procedure is considered non-reversible. Potential complications from a sleeve gastrectomy include:

1. _____ 2. _____ 3. _____ 4. _____

Required for all patients: I have calculated my Body Mass Index (BMI) and it is _____.

My current height is _____. My current weight is _____ lbs. (This information must be completed).

I agree to follow-up with my surgeon at this office even though it will involve some additional time and expense, and I will keep him informed of my status over the years. I have read and understand the information about bariatric surgery prepared by Cahaba Valley Surgical Group, PC.

Patient Signature

Date

Witness

Relationship to Patient

Shelby Baptist Bariatric Program

Patient Information Form

Demographic Information:				Chart#	
Last Name:		First:		Middle:	
Called By:		Maiden:			
Date of Birth:		Gender: F M U		Soc. Sec. #	
Marital Status: M S W D Other		Preferred Language:		Race/Ethnicity:	
Address:		Preferred Pharmacy:			
Zip:		City:		ST:	
Phone #s		Home:		Work:	
Cell:					
Email:		Preferred contact: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Web portal			
Employer:		Occupation:		Phone:	
Spouse:		Occupation:			
Financially Responsible Party:		<input type="checkbox"/> Self or list here:			
Relationship:		Contact Info:			
Billing Address:		Is your billing address different than the address above?			
Insurance Information:		Do you have health insurance you want us to file?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this visit due to injury or accident?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Is this a worker's compensation claim? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Insurance Co. #1		Contract / ID #		Group #	
Effective Date:		Are you the <u>Insured/Subscriber</u> or <u>Spouse</u> or <u>Dependent</u> on this policy?			
List the name or subscriber of this policy EXACTLY as listed on the insurance card:					
Subscriber DOB:		SSN:		- -	
Insurance Co. #2		Contract / ID #		Group #	
Effective Date:		Are you the <u>Insured/Subscriber</u> or <u>Spouse</u> or <u>Dependent</u> on this policy?			
List the name or subscriber of this policy EXACTLY as listed on the insurance card:					
Subscriber DOB:		SSN:		- -	
Referrals:		Who is your referring physician?			City/ST
Who is your primary physician (if different)?		City/ST			
Privacy Notice:		Please note that we maintain a Notice of Privacy Practices , which is posted at several locations in our waiting room. We also have copies that are accessible at the front desk that we encourage you to take and familiarize yourself.			
List any individuals with whom you give us permission to discuss your account and medical information, including but not limited to treatment, diagnosis, medications, test results or other types of protected health information in order to facilitate or coordinate treatment and payment for your services. You understand that the release of your information is voluntary and does not affect your access to treatment. You can choose NOT to disclose your information if you wish. You can revoke this authorization at any time by writing to Cahaba Valley Surgical Group, PC, or by filling out a new form.					
Name		Relationship		Contact #	
Name		Relationship		Contact #	
Name		Relationship		Contact #	

The staff of Cahaba Valley Surgical Group, P.C. thank you for entrusting us with your healthcare. **Please read this statement carefully and sign at the bottom of this form.**

I acknowledge that I am presenting to this office for evaluation and treatment, which may include surgery, medications and diagnostic tests. I authorize the release of any medical, insurance or other information necessary to treat me and coordinate my care, to process claims on my behalf, and authorize Cahaba Valley Surgical Group to do so if I have indicated that I have insurance for my services. I assign benefits for payment of insurance claims directly to the practice. I agree to be fully responsible for all lawful debts incurred for services I receive from Cahaba Valley Surgical Group, P.C., as well as medical services provided in any hospital setting necessary, whether covered by my insurance or not, including any collections fees if I do not pay my bill. I understand that my insurance may have a deductible, coinsurance, non-covered services, and/or pre-existing condition provisions and I will be fully responsible for any patient responsibilities as indicated by my insurance company.

Patient Signature (or Guardian) _____ **Date** _____

Shelby Baptist Bariatric Program

Chart # _____

Patient Name _____ Date of Birth ____/____/____ Age _____

Patient Height: _____ Weight _____ lbs. BMI _____ (Body Mass Index, if known) Today's Date: ____/____/____

Primary Care Physician: _____ Specialist (eg. Cardiologist) _____
 (Or Referring Physician)

Reason for visit (chief complaint): _____

Medical History: (Or None of these) (Check or circle all that apply)

<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Blood Clots <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Colitis <input type="checkbox"/> Cholesterol <input type="checkbox"/> Diabetes – Type I <input type="checkbox"/> Diabetes- Type II <input type="checkbox"/> Emphysema <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Gastric reflux <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Heart valve <input type="checkbox"/> Intestinal problems <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Lung disease <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Mental illness <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Mitral valve prolapsed <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Post-Menopausal <input type="checkbox"/> Poor Circulation (PVD)	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Stroke <input type="checkbox"/> TB <input type="checkbox"/> Thyroid problems <input type="checkbox"/> LMP: ____/____
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Other _____

Surgical History: (Or None of these) (Check or circle all that apply and indicate the year)

<input type="checkbox"/> Appendectomy__ <input type="checkbox"/> Amputation __ <input type="checkbox"/> Back__ <input type="checkbox"/> Bladder__ <input type="checkbox"/> Breast biopsy__ <input type="checkbox"/> Breast augmentation <input type="checkbox"/> Cystoscopy__	<input type="checkbox"/> Carotid Endarterectomy__ <input type="checkbox"/> Carpal tunnel__ <input type="checkbox"/> Cataract__ <input type="checkbox"/> Colon__ <input type="checkbox"/> Diagnostic laparoscopy__ <input type="checkbox"/> D & C__	<input type="checkbox"/> Gallbladder __ <input type="checkbox"/> Gastric banding/stapling__ <input type="checkbox"/> Gastric bypass__ <input type="checkbox"/> Heart__ <input type="checkbox"/> Hernia__ <input type="checkbox"/> Hemorrhoidectomy__	<input type="checkbox"/> Hysterectomy__ <input type="checkbox"/> Joint replacement__ <input type="checkbox"/> Knee Arthroscopy__ <input type="checkbox"/> Knee Replacement__ <input type="checkbox"/> Lung__ <input type="checkbox"/> Mastectomy__	<input type="checkbox"/> Prostate__ <input type="checkbox"/> Reflux (Nissen) __ <input type="checkbox"/> Stent Artery (heart/leg) <input type="checkbox"/> Shoulder Surgery__ <input type="checkbox"/> Thyroid__ <input type="checkbox"/> Tonsils__ <input type="checkbox"/> Tubal Ligation__
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Other _____

Medications: please list all current **medications, dose/strength, and frequency taken**—please include supplements, vitamins, & herbs

Name of Medication	dosage	freq	Name of Medication	dosage	freq	Name of Medication	dosage	freq

★ **Drug Allergies:** (please list drug and reaction) _____

★ **Other Allergies** (foods, pets, environmental): _____

Family History: please list illness in your family

Please indicate below significant medical problems of family members. Indicate which family members by <u>checking</u> (X) the appropriate column.	Mother	Father	Brother	Sister
Heart Disease				
High Blood Pressure				
Diabetes				
Cancer (Type)				
Other:				

Social History: (check or circle which best describes you)

Married Single Divorced Widowed Other Employed (job description: _____) Unemployed Retired
 Student (grade/level _____) Disability (due to _____)

Substance Use (check)	Current	Past	Never	Comments (frequency, amount, age started/stopped)
Alcohol Use				
Tobacco Use				
Illicit Drug Use				
Smokeless tobacco				

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Are you currently experiencing....?

Medical Evaluation Form

Chart # _____

Name: _____

(Please circle all that apply)

<p><u>Constitutional / General</u> <input type="checkbox"/> (Or None of these)</p> <p>Weight gain Weight loss</p> <p>Fever Chills Fatigue Body aches</p>	<p><u>Genitourinary (Urologic, GYN)</u> <input type="checkbox"/> (Or None of these)</p> <p>Blood in urine Burning on urination Pelvic pain</p> <p>Difficulty voiding Incontinence/wetting</p> <p>Vaginal discharge Abnormal uterine bleeding</p>
<p><u>Eyes</u> <input type="checkbox"/> (Or None of these)</p> <p>Impaired vision Blurred vision</p> <p>Recent changes in vision</p>	<p><u>Neurological</u> <input type="checkbox"/> (Or None of these)</p> <p>Headache Light headed/dizzy Seizure</p> <p>Numbness Tingling Memory difficulties</p>
<p><u>HENT (Ear, Nose Throat)</u> <input type="checkbox"/> (Or None of these)</p> <p>Hearing loss Sore throat Sinus drainage</p> <p>Neck tenderness Dental problems Thyroid mass</p>	<p><u>Musculoskeletal</u> <input type="checkbox"/> (Or None of these)</p> <p>Joint pain Foot/leg ulcers Muscle weakness</p> <p>Muscle cramps Back pain Muscle Pain</p>
<p><u>Breast</u> <input type="checkbox"/> (Or None of these)</p> <p>Breast pain Breast lump Nipple drainage</p> <p>Breast Tenderness</p>	<p><u>Endocrine</u> <input type="checkbox"/> (Or None of these)</p> <p>Cold intolerance Heat intolerance</p> <p>Hair loss Hot Flashes</p>
<p><u>Cardiovascular (Heart)</u> <input type="checkbox"/> (Or None of these)</p> <p>Chest pain Palpitations Swelling in legs/feet</p> <p>Varicose veins Leg pain with walking/ Claudication</p>	<p><u>Psychiatric</u> <input type="checkbox"/> (Or None of these)</p> <p>Depression Anxiety Abnormal stress</p> <p>Difficulty sleeping Impulsive Behaviors</p>
<p><u>Respiratory</u> <input type="checkbox"/> (Or None of these)</p> <p>Cough Coughing up blood Shortness of breath</p> <p>Asthma/wheezing Sleep Apnea</p>	<p><u>Hematologic / Lymphatic</u> <input type="checkbox"/> (Or None of these)</p> <p>Easy bruising Easy bleeding</p> <p>Lymph node enlargement</p>
<p><u>Gastrointestinal</u> <input type="checkbox"/> (Or None of these)</p> <p>Nausea Vomiting Abdominal pain Reflux</p> <p>Heartburn Diarrhea Constipation</p> <p>Blood in stool Mouth ulcers Hemorrhoids</p>	<p><u>Allergic / Immunologic</u> <input type="checkbox"/> (Or None of these)</p> <p>Sinus allergy symptoms Allergic dermatitis</p> <p>Frequent allergic illnesses</p>

Regarding the main reason you are here today, When did these symptoms begin? _____

Mild Mod. Severe

How long do they last? _____ How severe? (circle) 1 2 3 4 5

What treatment options have you tried? _____

Have you had any diagnostic tests for these problems (labs, X-rays, etc.)? _____

Reproductive History (Female Patients):

Menstrual History: When was your last menstrual period? _____

Your age at first menstrual period? _____ Age of menopause (if applicable)? _____

Obstetrical History: # of Pregnancies ____ # of Miscarriages ____ # of Live Births ____

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Patient Weight Loss / Diet History

Name: _____

Type of Weight Loss Program Attempted	Number of Times Tried	How long did you follow the diet?	What month/year did you follow the diet?	What were the results? (long/short term)
Weight Watchers				
LA Weight Loss				
Nutrisystem				
Overeaters Anonymous				
Prescription Diet Pills				
Psychotherapy (group or individual)				
Physician-supervised program				
Unsupervised Diet (Slim Fast, calorie counting, etc.)				
Behavior Modification				
Exercise programs				
Other				

Pregnancy & Bariatric Surgery

Cahaba Valley Surgical Group, P.C. makes a recommendation for all women of reproductive age to be especially aware of potential complications related to pregnancy during the first 12 – 24 months following weight loss surgery.

Many women consider themselves infertile and may have been unsuccessful in attempting to get pregnant in the past. For many of these women, underlying obesity is a major contributing factor to infertility. Women with severe obesity have about 3 times higher rates of menstrual disturbance. Obesity is associated with increased risks during pregnancy (high blood pressure, gestational diabetes, urinary infection, Cesarean section, and toxemia), and more complications during and after delivery.

In the obese state, fatty tissue holds onto normal hormones longer, and the body also produces an estrogen like hormone that can inhibit ovulation. It is common for the obese female to have scant, irregular or no menstrual cycle at all. About 1/3 of all infertility cases prescribe weight loss as the only treatment needed to get pregnant. With as little as a 15-20 pound weight loss, the odds of pregnancy are improved, and the miscarriage rate may be reduced by 2/3.

After surgery, you may resume sexual activity when you feel physically and emotionally able, but sexually active women of child bearing age need to use birth control. Please discuss forms of birth control with your gynecologist as some oral contraceptives may not be fully absorbed or have altered potency in patients undergoing gastric bypass surgery.

We recommend you wait at least 18months after weight loss surgery, and until your weight loss has plateaued before planning pregnancy. It is unsafe to conceive during the rapid weight loss phase post surgery as this may harm you and your baby due to potential nutritional deficits. There are increased risks of birth defects, fetal demise, and other pregnancy related risks if you become pregnant before your body has metabolically stabilized.

I have read this information on increased risks of pregnancy in the early phase following my planned bariatric surgery. I acknowledge that I may significantly increase my chance of becoming pregnant with even a small weight loss, and that I will take appropriate steps to ensure that I am using contraceptives correctly and consistently. Even though long term I am improving my fertility health, I am aware if I do become pregnant during the first 12-18 months post-op that I will be considered a high risk pregnancy and will need additional attention by qualified personnel.

Patient

(date)

witness

(date)

Permission for Medical Photographs

Consent for Photograph for Clinical Purposes

I, _____ (*patient name*) hereby consent for medical photographs to be made of me (or the person for whom I am legal guardian), prior to, during and after treatment. Unless stated below, photographs will be used only for documentation purposes, and will be maintained in the patient's confidential medical record. These photographs will remain the property of Cahaba Valley Surgical Group, PC.

Yes (consent)

No (do not consent)

Consent for Photograph for Marketing Purposes

I also consent for these photographs to be used for marketing purposes as an example of surgical results.

Yes (consent)

No (do not consent)

Patient Signature

Date

Thank you for helping us to document the quality and benefits of our surgical procedures.

-Cahaba Valley Surgical Group, PC

Financial Responsibility and Bariatric Surgery

What will I be financially responsible for before and after my surgery?

This form is required in order to process your paperwork.

- I agree and understand that I am fully responsible for coinsurance, copays and any amounts not covered by my insurance carrier, regardless of what type of insurance coverage I have.
- I understand that Cahaba Valley Surgical Group will attempt to certify my surgery with my insurance company, using all resources available. I also understand that this process may take several weeks to complete, depending on my personal coverage, and in accordance with my specific policy. I understand that I may not be approved at all for surgery.
- *****I also understand and will remit AT THE TIME OF SERVICE all payments for my initial consultation. This initial consultation is generally a non-covered service by most insurance companies and I will be responsible for remitting payment at the time of service. **The fee for the evaluation is \$250.00 and payable at the time of consultation.** We will file a claim for your consultation with your insurance company. If they do make payment for the visit, your consult fee will be refunded in full, less any applicable copayment indicated by the insurance company.
- I also understand that subsequent visits for post-op care, including B-12 injections, if applicable, are generally a non-covered benefit and I will be responsible for remitting payment for those services at the time of service.
- I understand that I may contact Cahaba Valley Surgical Group at 205-620-9065, or toll free at 866-622-0119, Monday through Friday, between 8:00 am and 4:00 pm and find out the actual amounts I will be charged for routine care. This will not include fees for services related to non-routine services or complications of surgery. Additionally, Cahaba Valley Surgical Group, PC does not set, quote, or collect fees for hospital charges in connection with your procedure.
- Occasionally, some policies may cover related post-op care or other services noted above. Cahaba Valley Surgical Group will bill your insurance company for all services.
- I understand that bariatric surgery patients have certain requirements to follow up with their surgeon following surgery. This schedule may differ based on the procedure you have. Your surgeon will discuss a post operative follow up schedule with you. Laparoscopic adjustable gastric band patients will be required to follow-up a number of times during the first post-op year, and occasionally thereafter. At annual visits, your surgeon may order labs to assess your nutritional status. All charges incurred at these visit will be filed with your insurance company. In the event they are non-covered due to diagnosis or other reason, you will be financially responsible for these visits.
- I understand that if, at any time after my insurance company pays for my surgery, if services are deemed non-covered due to non-payment of premium or retroactive termination of my policy, I will be financially responsible for all charges incurred with my procedure.
- I understand that my surgeon's office collects the patient's responsible payment (co-insurance) through pre-payment arrangements in advance of my procedure.
- I have read and understand my financial responsibilities regarding payments due to Cahaba Valley Surgical Group, PC. I understand that payment for services, including initial consultation and any co-insurance or cost-sharing required by my insurance, are due at the time of service, regardless of the outcome of my insurance filing.

Patient Signature: _____ Date: _____

Witness: _____

Shelby Baptist Bariatric Program

Insurance and Bariatric Surgery

If you are planning on using your insurance to pay for your bariatric surgery, there are some important points to consider.

There are several components that work together toward paying for your surgery. Your insurance company will be billed by the hospital for facility related services (pre-admission, OR, nursing, ancillary services, medications while inpatient, to name a few), and your surgeon will bill your insurance company for the surgeon's professional services (ie, the actual surgical procedure). In many cases, the anesthesiologist bills the insurance company directly for their own professional services (general anesthesia for your procedure). Do not be surprised to see more than one Explanation of Payment or Benefits from your insurance company. These correspond to the different claims the company has received regarding your surgery. Also, do not be alarmed by bills you receive from the hospital soon after your surgery. These are often just a restatement of what is being billed to the insurance company, and do not necessarily reflect what you will owe.

Be sure to contact the hospital directly for any questions you may have regarding a hospital bill. Contact the surgeon's office directly regarding any questions you have regarding their statements. The hospital will not be able to answer questions about the surgeon's statements, and vice versa.

What insurance plans do you accept?

Shelby Baptist Medical Center accepts a wide array of insurance plans. Cahaba Valley Surgical Group accepts numerous plans, as well. Some of these include:

- Blue Cross and Blue Shield Plans
- United Healthcare
- Tricare
- Other commercial health plans

*Some plans require a referral from the primary care physician. Some plans have specific hospital panels within which the patient must receive services. Call your insurance company to inquire.

We do not accept the following insurance plans for our Bariatric Program, but are happy to consult you on a private pay basis:

- Medicare, Medicare Advantage Plans, Aetna, Cigna, Medicaid (all state programs)

What if I have two insurance plans (a primary and secondary)?

Our Bariatric Program uses a patient's **primary** insurance plan for coverage and review/approval criteria. In the instance where the patient has no coverage on the primary policy but benefits on the secondary, we do not file with the primary and obtain a denial. We, and your insurance company, do not get to choose which policy to apply. Your primary coverage will always apply in this program. It is very important for you to let us know of all insurance policies you have.

I don't think that my insurance covers this procedure, but the Customer Service representative I spoke to said that all my doctor has to do is submit a letter of medical necessity.

The process of gaining insurance approval is time consuming and labor intensive. We exhaust significant resources to assist our patients in navigating the insurance review process. However, we will not submit your information to your insurance company "to see if they will cover it". If we have verified your eligibility and benefits through your plan and there is no coverage for bariatrics, you may proceed as a private pay patient and we will be happy to assist you in that capacity.

Shelby Baptist Bariatric Program

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your private health and financial information is protected by federal and state laws. We are required to uphold specific standards to protect and secure that information. By presenting to our office and signing below, you hereby consent for Cahaba Valley Surgical Group, PC to use or disclose information about yourself (or another person for whom you have the authority to sign) for the sole purposes of treatment (coordinating, arranging and delivering care, including referrals to other healthcare providers for your treatment), payment (which may include filing claims or sending statements, including medical information to support processing claims) and health care operations. You may refuse to sign this consent form.

We maintain a Notice of Privacy Practices which is posted in our office, of which copies are available to you at our registration desk.

You have the right to request that the Practice restrict how protected health information (PHI) is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

AUTHORIZATION FOR COMMUNICATIONS

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Cahaba Valley Surgical Group, PC representative or my physician to mail, call, e-mail, or publish to a secure encrypted website (if I so indicate) with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Cahaba Valley Surgical Group, PC to that effect in writing.

TREATMENT CONSENT

I hereby consent to evaluation, testing, and treatment as directed by my Cahaba Valley Surgical Group, PC. physician or his/her designee.

Acknowledged-

Signature

Date

For the Surgeons of Cahaba Valley Surgical Group, P.C.
644 2nd Street NE 2nd Street NE, Suite 206, Alabaster, AL 35007
205-620-9065 Fax: 205-620-9051

Blood Product Release

The practice of surgery is an invasive art with inherent risks. One of the risks of performing bariatric surgery, laparoscopic or open, is the risk of bleeding. We use all means available to minimize this risk and rarely are blood or blood products necessary. The use of blood products, when needed, however, can be life saving.

Some patients have personal or religious reasons for refusal of blood transfusions, choosing instead death over the use of blood products, even if medically necessary. While we respect those personal beliefs, our physicians do not feel they could allow a patient to die from an elective operation when a blood transfusion might save the patient's life. Therefore, we cannot guarantee against the use of blood or blood products during or after **gastric bypass** or **laparoscopic adjustable gastric banding**. If you desire to continue with this practice for your surgery, you acknowledge and consent to an elective bariatric surgical procedure from a surgeon who will use life saving measures, including blood transfusions, if it is deemed necessary by the surgeon to save your life.

I have read this form, and acknowledge by signing it I am agreeing to receive blood and/or blood products at the discretion of my surgeon or other physicians involved in my care, should that be deemed necessary at the time of my surgery.

Signature of Patient or Authorized Parent or Guardian

Date Signed: _____

Shelby Baptist Bariatric Program

BARIATRIC FORMS CHECKLIST

Use this list to help you complete your required paperwork. All patients will be contacted within 30 business days of our receipt of your packet.

We require **original signatures**, so please **mail**, rather than fax your information.

- Request for Bariatric Surgery
- Patient Information Form
- Medical Evaluation Form
- Patient Weight Loss/Diet History Form
- Pregnancy and Bariatric Surgery
- Permission for Medical Photographs
- Financial Responsibility & Bariatric Surgery
- Insurance and Bariatric Surgery
- Consent for Release of Medical Information
- Blood Product Release

Each form listed must be completed before we can process your paperwork. Incomplete forms will be returned. Until a completed enrollment packet is received, you will not be fully enrolled in our bariatric program.

**It will greatly expedite the review of your information if we have a copy of the front and back of your insurance card along with your completed packet of forms.*

Please mail your completed packet to:

**Shelby Baptist Medical Center
Bariatric Program
1000 1st Street North
Alabaster, AL 35007**

Please allow 2-4 weeks for us to process your packet and provide a response. You will be contacted by mail with information regarding your application, insurance requirements, and the process of obtaining a consultation with the surgeon.

Thank you, again, for your interest in the Shelby Baptist Bariatric Program.