Dear Interested Surgical Candidate,

We would like to take this opportunity to thank you again for choosing Atrium Health Weight Management. By attending our informational session, you should have many of your questions answered. By attending the session and seeking more information, you have made steps towards a life changing decision. There are many guidelines in the program that are necessary for your surgical care. We want you to be prepared and informed as our patient. The goals of our team are to provide you with excellent care, education, and assistance throughout the surgical process.

You will need to actively participate in a multidisciplinary program for bariatric surgery which includes nutrition, behavioral and exercise counseling. Our highly trained team is committed and excited to partner with you on your journey to better health.

Please read and fill out all the forms provided in this packet. Please do not date anything in the packet until the day of your appointment. It is mandatory that you bring the completed packet with you to your initial surgical appointment. Failure to complete the packet before your appointment may result in rescheduling the appointment. Please do not mail or fax in the packet. If you would like a copy of the packet for your records, please make a copy prior to your office visit.

If you have questions about the packet, please phone our Bariatric Hotline at 704-355-9484. If you must cancel your appointment for any reason, please contact our office as soon as possible to reschedule. Failure to cancel your appointment 3 times will result in you being dismissed from the practice. This is an Atrium Health policy.

At your initial appointment you will need to bring your insurance cards, specialty copay or $50 towards your deductible, and your completed packet.

We look forward to meeting with you soon!

Sincerely,
Your Bariatric Surgery Team

If you would like to verify that your insurance provider covers bariatric surgery on your specific plan or the cost estimates of the procedures, provide them with the CPT codes listed below. If you need information on surgery costs, you may call the “Insurance & Price Estimation” hotline at 704-355-0900.

CPT Codes Procedure:
43644 Laproscopic Roux-en-Y Gastric Bypass
43775 Laproscopic Vertical Sleeve Gastrectomy
43775/43659 Laproscopic Duodenal Switch
43770 Laproscopic Adjustable Gastric Band
97802 Medical Nutrition Therapy—Initial visit
97803 Medical Nutrition Therapy—Follow-up visit
97804 Medical Nutrition Therapy—Group visit
Atrium Health Weight Management
2630 E. 7th Street, Suite 100
Charlotte, NC 28204
704.355.9484

From I-77 South:
Start at I-77
Take exit #9/JOHN BELK FRWY/WILKINSON/onto I-277 North towards 9B/JOHN BELK FRWY
Take exit #2A/KENILWORTH AVE/THIRD ST/FOURTH ST towards THIRD ST/FOURTH ST.
Take the 3rd ST. Exit.
Take a Right on to 3rd St; then get in your far left lane.
Take a Left on to KINGS DR. Go pass CPCC College, continue until you see E 7th ST.
Take a Right on E 7th ST.
At the intersection of E. 5th ST, (on the Right) and Firefighter St (on your left), go through the stop light.
2630 E 7th ST is the second driveway on your Right. (Eastover Medical Park III—only 2 story building)
If you go to Lupie’s Restaurant you have gone too far.

From I-85 South:
Take I-85 North.
Take exit #36/BROOKSHIRE FREEWAY/DOWNTOWN (US-74 EAST) onto BROOKSHIRE FREEWAY
(NC-16 S) toward Charlotte/Bank of America Stadium.
Take the BEVARD ST/DAVIDSON ST/MCDOWELL ST exit.
Continue on N. MCDOWELL ST.
Turn Left on E.7th ST. (NC-27).
Continue on E.7th ST. at the intersection of E.5th ST. (on the Right) and Firefighter St on your Left go through the stop light.
2630 E 7th ST will be the second driveway on your Right. (Eastover Medical Park III—only 2 story building)
If you go to Lupie’s Restaurant you have gone too far.

From I-85 North:
1. Take I-85 South
2. To I-77 South
3. Take exit 11 for I-277 S/Brookshire Freeway E/NC- 16 S
4. Take exit 2B on the left US-74 E/NC 27 E toward Independence Blvd
5. Slight Right at Briar Creek Rd, then turn left onto Briar Creek.
6. Turn Right at Monroe Rd
7. Continue on E 7th St.
8. Once you pass Lupie’s Restaurant on your left, go to the 1st drive way on the Left. (Eastover Medical Park III—only 2 story building)
9. If you go to the stop light at the intersection of E.5th and Firefighter St, you have gone too far.
Atrium Health Weight Management
Ballantyne Office

**Ballantyne Office Address**
14214 Ballantyne Lake Road, Suite 200, Charlotte, NC 28277

**Phone Number’s**
704-667-2681—Ballantyne
704-355-9484—Main office

**Directions**
From I-485, Take Exit 61 for US 521-Johnston Road
Merge onto US 521 South-Johnston Road
Turn left onto the second John J. Delaney Drive
Take first right onto Ballantyne Lake Road
Destination will be on the right
The practice is located in the middle of the complex-between Urgent Care and Providence Pediatrics
Atrium Health Weight Management
Gastonia Office

Gastonia Office Address
2550 Court Drive #202, Gastonia, NC 28054

Phone Number’s
704-861-2290—Gastonia
704-355-9484—Main office

Directions
From Charlotte:
Take I-85 S to exit 21 (Cox Road)
Turn Left onto Court Drive, office will be on the right.

From Kings Mountain:
Take I-85 N to exit 20 (NC-279/New Hope Rd)
Turn Let onto NC-279 W/N New Hope Rd
Turn Right onto Court Drive, office will be on the left
From I-85:

- Take Exit 60
- At the top of the ramp, turn right onto Copperfield Blvd. NE
- Take first left onto Dicken’s Place NE
- Take first right onto Vinehaven Drive NE
- Destination will be on the left
Obese

Body Mass Index (BMI) is a number calculated from an individual’s height and weight that is used to determine whether a person is within a normal weight range.

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight in Pounds</th>
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<tbody>
<tr>
<td>4'11&quot; - 5'0&quot;</td>
<td>100 - 120</td>
</tr>
<tr>
<td>5'0&quot; - 5'1&quot;</td>
<td>120 - 140</td>
</tr>
<tr>
<td>5'1&quot; - 5'2&quot;</td>
<td>140 - 160</td>
</tr>
<tr>
<td>5'2&quot; - 5'3&quot;</td>
<td>160 - 180</td>
</tr>
<tr>
<td>5'3&quot; - 5'4&quot;</td>
<td>180 - 200</td>
</tr>
<tr>
<td>5'4&quot; - 5'5&quot;</td>
<td>200 - 220</td>
</tr>
<tr>
<td>5'5&quot; - 5'6&quot;</td>
<td>220 - 240</td>
</tr>
<tr>
<td>5'6&quot; - 5'7&quot;</td>
<td>240 - 260</td>
</tr>
<tr>
<td>5'7&quot; - 5'8&quot;</td>
<td>260 - 280</td>
</tr>
<tr>
<td>5'8&quot; - 5'9&quot;</td>
<td>280 - 300</td>
</tr>
<tr>
<td>5'9&quot; - 6'0&quot;</td>
<td>300 - 320</td>
</tr>
</tbody>
</table>

BMI Chart

ATRIUM HEATH WEIGHT MANAGEMENT

FOR MEDICAL APPOINTMENTS, QUESTIONS OR TO SIGN UP FOR A SINGULAR INFORMATION SESSION, PLEASE PHONE:

WWW.CAROLINAWEIGHTMANAGEMENT.ORG
Surgical Patient History Form

Name: ____________________________________________ DOB: ___/___/____

Which surgical procedure are you interested in? (please check box)

☐ Gastric Bypass    ☐ Sleeve Gastrectomy    ☐ Lap Band    ☐ Revision of Previous Surgery    ☐ Undecided

Medical History (Please circle yes or no to the following questions)

Has a Doctor or Health Professional ever told you that you have or treated you for any of the following?

Nervous System:
Stroke, mini stroke, or one-sided weakness?    NO    YES
Chronic headaches/migraines?    NO    YES
Seizures?    NO    YES
Numbness or tingling in neck, arms or hands?    NO    YES

Heart and Circulation:
High blood pressure?    NO    YES
High cholesterol?    NO    YES
Congestive heart failure?    NO    YES
Heart attack?    NO    YES
Heart valve abnormalities?    NO    YES
Abnormal heart rhythms?    NO    YES
Do you ever experience chest pain or palpitations?    NO    YES
Symptoms with exercise?    NO    YES
If yes, explain:________________________________________________
Heart stress test?    NO    YES
Cardiac catheterization or angioplasty?    NO    YES
Pacemaker or implantable defibrillator?    NO    YES

Lungs and Breathing:
Sleep apnea?    NO    YES
CPAP or BIPAP machine?    NO    YES
Have you ever had a sleep study?    NO    YES
Asthma?    NO    YES
Emphysema or COPD?    NO    YES
Pulmonary embolus?    NO    YES
How many blocks can you walk without becoming short of breath?
(Please circle one of the choices below)
Less than ½ block    ½ block    1 block    1-2 blocks    more than 2 blocks

Physician use only

HT__________
WT__________
BMI__________

PCP:___________________________
INS:____________________________
Liver, Gallbladder, Stomach, Intestine:

GERD/Acid Reflux?  NO  YES
Heartburn?  NO  YES
  If yes, how many times per week?  _____ times/week
Difficulty swallowing food or liquid?  NO  YES
Gallstones?  NO  YES
Pancreatitis?  NO  YES
Cirrhosis?  NO  YES
Stomach/duodenal ulcers?  NO  YES
Hiatal hernia  NO  YES
Hepatitis (A, B or C)?  NO  YES
Crohns/Ulcerative Colitis?  NO  YES
Irritable Bowel Syndrome?  NO  YES
Chronic constipation?  NO  YES
History of GI cancer?  NO  YES
Have you ever had a colonoscopy, barium enema or upper endoscopy?  NO  YES
If yes, include the date and reason why:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Blood and Clotting:

Are you willing to accept a blood transfusion?  NO  YES
Anemia?  NO  YES
Sickle Cell disease?  NO  YES
Clotting or platelet disorder?  NO  YES
Deep Venous Thrombosis (DVT – blood clot in your arm, leg, chest, etc?)  NO  YES
Have you ever been on Coumadin?  NO  YES
Are you on any of the following?
  Aspirin  Plavix  NSAIDs (Ibuprofen, Advil, Motrin, Naprosyn)
Name:_____________________________________________________________________
DOB:_____/_____/_____

**Endocrine:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes?</td>
<td></td>
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<tr>
<td>Thyroid disease?</td>
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<tr>
<td>Polycystic ovarian syndrome? (PCOS)</td>
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<tr>
<td>Cushings Disease?</td>
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<td></td>
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<tr>
<td>Excessive thirst, hunger, urination?</td>
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<tr>
<td>Visual changes (wavy lines, spots)?</td>
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<tr>
<td>Change in body temperature (very cold or hot)?</td>
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</tbody>
</table>

**Miscellaneous:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
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</thead>
<tbody>
<tr>
<td>Depression?</td>
<td></td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Other psychiatric disorder?</td>
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<tr>
<td>Joint pain (hip, knee, ankle, lower back)?</td>
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<tr>
<td>If yes, circle areas that are affected</td>
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<td></td>
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<tr>
<td>Lower back hip knee ankle</td>
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<td></td>
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<tr>
<td>Urinary stress incontinence?</td>
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<tr>
<td>If yes, how many pads do you use per day</td>
<td></td>
<td>pads/day</td>
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<tr>
<td>Kidney Stones and/or other kidney disease?</td>
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<tr>
<td>HIV?</td>
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<td></td>
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<tr>
<td>Autoimmune disease (rheumatoid arthritis, Lupus, etc.)</td>
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<tr>
<td>If yes, please explain:</td>
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</tbody>
</table>

___________________________________________________________
___________________________________________________________

**Pregnancy History:**

<table>
<thead>
<tr>
<th>Question</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times have you been pregnant?</td>
<td></td>
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<tr>
<td>How many times have you delivered?</td>
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<tr>
<td>Have you ever had a c-section?</td>
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<tr>
<td>If yes, how many?</td>
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<tr>
<td>Complications following delivery or c-section?</td>
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<tr>
<td>Problems during pregnancy (high BP or blood sugar)?</td>
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<tr>
<td>Have you ever had a tubal ligation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had problems becoming pregnant?</td>
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</tr>
</tbody>
</table>

If yes, please explain:

___________________________________________________________
___________________________________________________________
Surgical History:
Have you ever had prior surgery?  NO  YES
Have you ever had weight loss surgery?  NO  YES
If yes, list all surgeries that you have had and the year in which they occurred:
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Have you ever experienced any of the following after surgery?
Blood clots  NO  YES
Abnormal bleeding  NO  YES
Problems with anesthesia  NO  YES
If yes, please explain:
____________________________________________________________
____________________________________________________________

Difficulty healing?  NO  YES
If yes, please explain:
____________________________________________________________
____________________________________________________________

Drug Allergies?  NO  YES
If yes, describe the reaction you had:
____________________________________________________________
____________________________________________________________

Social History:
Current Smoker?  NO  YES
    If yes, how much do you smoke (pack(s)/day): _____ pack(s)/day
    How many years have you smoked? _____ years
Past smoker?  NO  YES
    If yes, indicate the number of months since you quit: _______months
Drink alcoholic beverages?  NO  YES
    If yes, indicate the number of drinks/week: _____ drinks/week
Current IV drug use?  NO  YES
Past IV drug use?  NO  YES
Name: ___________________________________________________________ DOB: _____/_____/_____

**Social History (continued):**

Do you live alone? NO YES
Do you use a wheelchair or walker? NO YES

**Occupation:** ___________________________________________

**Family History (parents and siblings):**

Check here if your family history is unknown

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
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<tr>
<td>High cholesterol</td>
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<tr>
<td>Bleeding</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Heart disease</td>
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<tr>
<td>Heart attack</td>
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<tr>
<td>DVT (blood clots in arm, leg, chest, etc.)</td>
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<tr>
<td>Cancer</td>
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<td></td>
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<tr>
<td>Anesthesia difficulty</td>
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<tr>
<td>Sleep apnea</td>
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<tr>
<td>Asthma</td>
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</tbody>
</table>

Please check all previous weight loss program or medications you have tried:

<table>
<thead>
<tr>
<th>Program</th>
<th>Date</th>
<th>Weight (lost or gained)</th>
<th>Length of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Watchers</td>
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<tr>
<td>Overeaters Anonymous</td>
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<tr>
<td>Liquid diets (optifast)</td>
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<tr>
<td>Diet pills (phen-fen, redux)</td>
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<td>Diet pills (meridian, Xenical)</td>
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<td>Diet pills (phentermine)</td>
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<td>Diet pills (Topomax)</td>
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<td>Nutrisystem</td>
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<td>Jenny Craig</td>
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<td>OTC diet pills</td>
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<td>Nutritionist/Dietitian</td>
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<td>Surgery</td>
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<tr>
<td>Other</td>
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</table>

**Physician use only**

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Atrium Health
Atrium Health Weight Management
Surgical Patient History Form

Patient Information or Label

Name:
DOB:
Medical Record #: 
Current Medications:
Please include all prescriptions and over the counter medications, herbs and vitamins. You may bring a separate list.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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</table>
Atrium Health Weight Management
Patient’s Physician Information

Patient’s Name:__________________________________________________________________________________
(First) (M.I.) (Last)

Primary Care Physician:__________________________________________________________________________
(First) (M.I.) (Last)
Practice Name:__________________________________________________________________________________
Practice Address:________________________________________________________________________________
City/State:______________________________________________________________________________________
Phone #:_____________________________________ Fax:_______________________________________________

Referring Physician:______________________________________________________________________________
(First) (M.I.) (Last)
Practice Name:__________________________________________________________________________________
Practice Address:________________________________________________________________________________
City/State:______________________________________________________________________________________
Phone #:_____________________________________ Fax:_______________________________________________

Specialist Physician:____________________________________________________________________________
(First) (M.I.) (Last)
Practice Name:__________________________________________________________________________________
Practice Address:________________________________________________________________________________
City/State:______________________________________________________________________________________
Phone #:_____________________________________ Fax:_______________________________________________

Other Physician:________________________________________________________________________________
(First) (M.I.) (Last)
Practice Name:__________________________________________________________________________________
Practice Address:________________________________________________________________________________
City/State:______________________________________________________________________________________
Phone #:_____________________________________ Fax:_______________________________________________