

Greetings,

Thank you for your interest in having weight loss surgery at Sanford Health in Bismarck.

We perform gastric bypass, sleeve gastrectomy and lap banding. All three vary in how they are performed, their recovery time and which procedure is suited for each individual.

Before making any decisions or attending our information session, we recommend you find out what your insurance company will and will not cover regarding weight loss surgery. The process to be considered for weight loss surgery is lengthy and can be complicated.

Below are some steps and examples of guidelines your insurance company may require before approving your surgery.

- Start with asking if your policy has benefits for weight loss surgery. Use the insurance worksheet provided in this packet as a guide to use when speaking with your insurance company.
- Most insurance companies require a body mass index (BMI), a calculated number based on your height and weight, of 40 or greater. In some instances, they may allow surgery if you have a BMI greater than 35 and have related medical conditions. A BMI chart is included for your reference.
- You may need to show your previous weight loss efforts. This usually means your primary care physician has documented that you have received weight loss counseling. You will need to provide the last three to five years of your medical records.
- Before your information is submitted to an insurance company for preauthorization, you will be required to have a psychological evaluation. This will assess whether or not you can comply with the necessary steps involved with this surgery and the lifelong changes you will need to make. This does not need to be completed before you attend an informational session.

After speaking with your insurance company, you can:

- Attend an information session, where you will review the basic concepts of obesity, learn details about the above requirements and receive an overview of our weight loss surgery program.
- Bring the completed packet documents to the information session. If you do not bring completed documents, please complete them as soon as possible and send to the weight loss surgery department office. A nurse will review your medical information and call you to discuss. You cannot make an appointment with a surgeon without first attending an information session and handing in your packet. It is also recommended that your primary care physician send us a referral letter.
- Schedule an appointment at Sanford Clinic in Bismarck. A clinical examination will be performed, additional tests may be ordered and your photo will be taken. Your information will then be submitted to your insurance company to complete the preauthorization process.

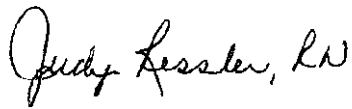
If and when your insurance company approves you for surgery and our office receives the approval letter, a nurse will call you to set up a surgery date. The entire process usually takes several months to complete. This may require three to four visits to the clinic and/or hospital.

We understand this is a long and involved process, but encourage you not to become frustrated. These are necessary steps to ensure the safety and long-term success of your procedure. Just remember, you will have the rest of your life to enjoy the benefits.

We hope to see you at our upcoming information session. If you have any questions, please call (701) 323-5530.

To learn more about the weight loss procedures offered at Sanford Health, visit bismarck.sanfordhealth.org/weightlossurgery.

Sincerely,

A handwritten signature in black ink that reads "Judy Ressler, RN". The signature is written in a cursive style with a large initial "J".

Judy Ressler, RN, Bariatric Coordinator
Sanford Health Weight Loss Surgery

Insurance worksheet

Contact your insurance company

The name of the insurance representative you spoke with: _____

Date: _____

ASK:

Is bariatric surgery for morbid obesity covered under your policy? Yes No

What steps do you need to take in order to qualify for surgery?

- How many months of formal physician supervised weight loss attempts (Dietitian) do they require? _____
- Do the dietitian notes need to be signed by the physician? _____
- If so please notify our office 323-5300
- Do the months need to be cumulative or consecutive? _____

Do you need a referral from your Primary Care Provider (PCP) to see the surgeon? _____

- Can the surgeon refer you to the Dietitian and Psychiatrist, or do you need your PCP to do referrals for those services as well? _____

Does your policy cover dietitian visits related to weight loss? _____

- If so, how many per year? _____
- Do they cover group visits or individual visits? _____

Some plans have a yearly cap for inpatient and/or outpatient services. Once that amount is reached the patient is responsible for all charges over the stated amount.

Does your policy have an annual or lifetime cap on coverage for surgery? _____

- **If so:**
 - What is it? \$ _____
 - Is it for in-patient or out-patient services, or both? _____

▷ It is very important that you understand your insurance policy and their requirements for surgery. It will be up to you to make sure those requirements are met. We are here to help you, please feel free to call if you need to.

▷ Don't be afraid to continue to ask questions if you are told to look on-line or refer to your benefits book. They are there to help you understand your policy.

Medicare and those with 2 or more insurance policies

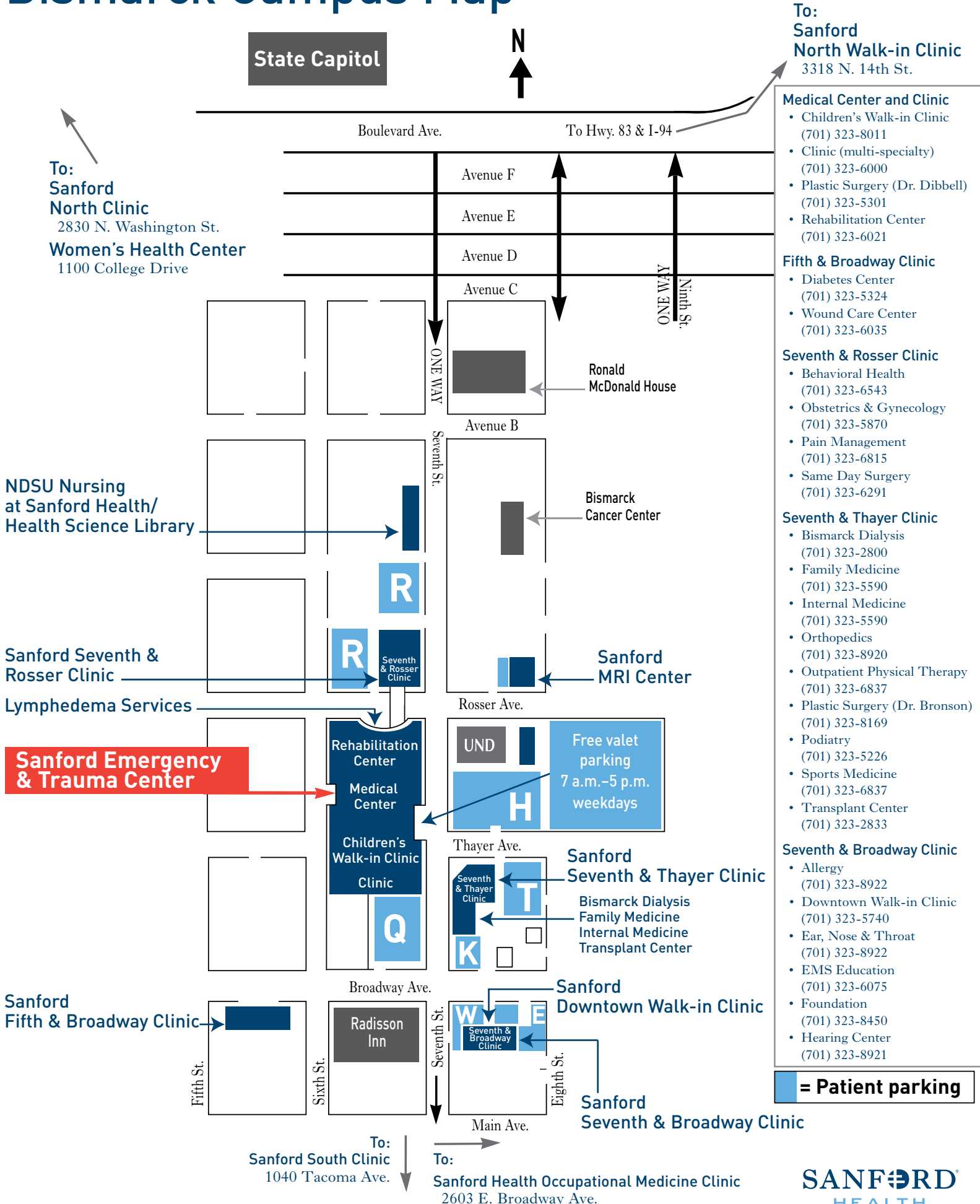
If you carry more than one policy, especially Medicare, you will need to call that second company and find out if your policy processes claims as a supplement or a true secondary insurance. It is also important to figure out which insurance is your primary insurance.

What's the difference between supplemental and secondary coverage?

▷ **Supplemental** coverage bases it's payments on what Medicare pays. If Medicare does not pay for the surgery, your supplemental policy will most likely deny it as well.

▷ **Secondary** coverage usually processes claims independent of what the primary insurance does. It is important to call your secondary and understand their policy and the way it pays.

Bismarck Campus Map



To:
Sanford North Walk-in Clinic
 3318 N. 14th St.

- Medical Center and Clinic**
- Children's Walk-in Clinic (701) 323-8011
 - Clinic (multi-specialty) (701) 323-6000
 - Plastic Surgery (Dr. Dibbell) (701) 323-5301
 - Rehabilitation Center (701) 323-6021

- Fifth & Broadway Clinic**
- Diabetes Center (701) 323-5324
 - Wound Care Center (701) 323-6035

- Seventh & Rosser Clinic**
- Behavioral Health (701) 323-6543
 - Obstetrics & Gynecology (701) 323-5870
 - Pain Management (701) 323-6815
 - Same Day Surgery (701) 323-6291

- Seventh & Thayer Clinic**
- Bismarck Dialysis (701) 323-2800
 - Family Medicine (701) 323-5590
 - Internal Medicine (701) 323-5590
 - Orthopedics (701) 323-8920
 - Outpatient Physical Therapy (701) 323-6837
 - Plastic Surgery (Dr. Bronson) (701) 323-8169
 - Podiatry (701) 323-5226
 - Sports Medicine (701) 323-6837
 - Transplant Center (701) 323-2833

- Seventh & Broadway Clinic**
- Allergy (701) 323-8922
 - Downtown Walk-in Clinic (701) 323-5740
 - Ear, Nose & Throat (701) 323-8922
 - EMS Education (701) 323-6075
 - Foundation (701) 323-8450
 - Hearing Center (701) 323-8921

= Patient parking

To:
Sanford North Clinic
 2830 N. Washington St.
Women's Health Center
 1100 College Drive

NDSU Nursing at Sanford Health/
 Health Science Library

Sanford Seventh & Rosser Clinic
 Lymphedema Services

Sanford Emergency & Trauma Center

Sanford Fifth & Broadway Clinic

To:
Sanford South Clinic
 1040 Tacoma Ave.

To:
Sanford Health Occupational Medicine Clinic
 2603 E. Broadway Ave.

Sanford Health

Weight Loss Surgery Questionnaire Packet

Psychological Evaluation Centers

You are not limited to these providers. If you are interested in using a different provider, ask if they do the psychological evaluation for weight-loss surgery approval.

Bismarck

Sanford Health
323-6543
Richard Arndorfer, Ph.D.
M. Schaaf-Gallagher, Ph.D.
K. Ghering, Ph.D.
C. Herrick, Ph.D.

St. Alexius PrimeCare
530-7300
David Brooks, Ph.D.

Other:
Ed Kehrwald, Ph.D. - 224-1897
Christine Kuchler, Ph.D. - 224-1897

Minot

Julie Rickert, Ph.D. - 858-6700
Timothy Eaton, Ph.D. - 839-0474 --
(United Health Care approved)

Belcourt IHS (Tribal Enrolled)

Angie LaRoque, Ph.D. - 477-8658
Tammy Trottier, Ph.D. - 477-8659

Dickinson

Robert Baer - 483-9720
Shelly Goodrich - 225-1050

Carrington

John Collins, Ph.D. - (800) 526-8648

Devils Lake

Greg Volk, Ph.D. - 662-1911
Dr. Volk travels to Williston, Dunseith, and Rugby every other week each month.
Call Volk Human Services for appointment at (701) 662-1911.
Sara Kenney, PsyD. (701) 662-8255

Jamestown

Sanford Health 2nd Ave. Clinic
John Collins, Ph.D. - (800) 442-3010 and 952-6003

Sanford Health Weight Loss Surgery Questionnaire Packet

Greetings,

If you would like to get started with the surgery approval process, here are the steps you need to take:

- Check with your insurance company to make sure your policy covers the procedure. When you talk to them, ask about your policy specifically.
- Complete the patient information booklet, the paper with insurance information and the consent to this clinic.
- Please give the completed and signed information release forms to your primary care doctor's office, and instruct them to send your medical records to our office.
- Returning the release to this clinic will slow the process. Generally we require at least three years of records. I will contact you if more are required.
- If you are sure you meet the criteria for surgery, you will want to consider getting your psych evaluation done. If you are unsure if you qualify, please call me so we can review the information in your packet.
- If your records are with Sanford Health, please enclose a note mentioning your doctor's name with your paperwork so your records can be found.
- If you do not complete this packet prior to your information session, please fill it out and mail it to our office. It seems like a long process, but it goes quite smoothly. The longest process to complete is the record release and psych evaluations. These are all necessary to the process.

Call me if you have any questions or need help getting through this process.

Sincerely,

Judy
Registered Nurse, Bariatric Coordinator
Receptionist: (701) 323-5300

bismarck.sanfordhealth.org/weightlosssurgery



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Weight Loss Surgery Questionnaire Packet

Consent

Date: _____

I give my verbal and written consent for Sanford Health to release all of the information of my past medical history, including psychological evaluations, supervised and unsupervised weight loss programs, etc.

All information regarding my past and present medical history may be copied and released to my insurance company, Medicare, Medicaid, etc. for pre-authorization for gastric bypass/lap band surgery due to morbid obesity.

Patient Signature: _____

May we leave a message on your answering machine at work or home? Yes No

May we leave a message with your spouse or significant other? Yes No

Patient Signature: _____

Insurance Information

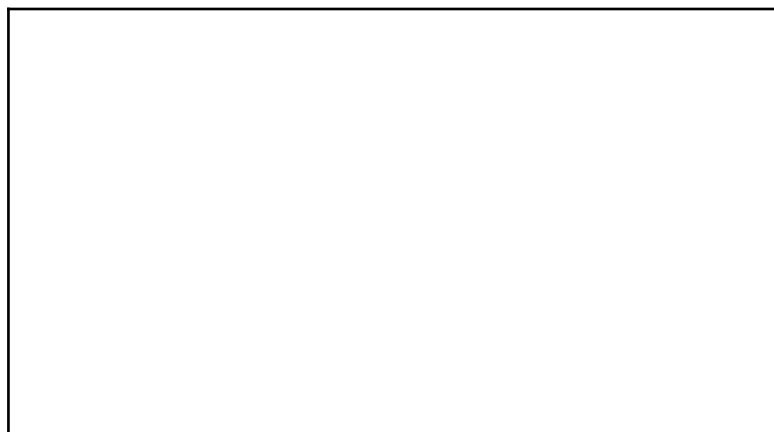
Insurance Company Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

bismarck.sanfordhealth.org/weightlosssurgery





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Weight Loss Surgery Questionnaire Packet

Date: _____ Name: _____

Nickname: _____ Allergies: _____

Sex: Male Female Ethnic Origin: Caucasian African American Asian Native American
 Hispanic Other: _____

SSN#: _____ DOB: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Height: _____ Weight: _____

Doctor referred by: _____

Marital Status: Married Single Separate Divorced Widowed

Education: _____ High School Graduate: _____

Years in college: _____ Years in post grad: _____

Occupation: _____

Employment (Full time or Part time): _____

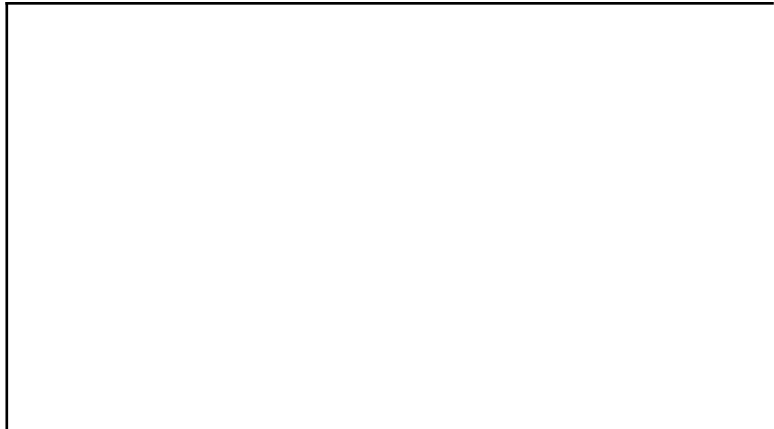
Present: _____ Past: _____

If you are using the following, please indicate how much and how often.

Tobacco (chewing, cigars, or cigarettes): _____

Alcohol: _____ Caffeine: _____

Recreational/street drugs: _____





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Weight Loss Surgery Questionnaire Packet

Medical History

Please list any surgical procedures with either year or your age at procedure:

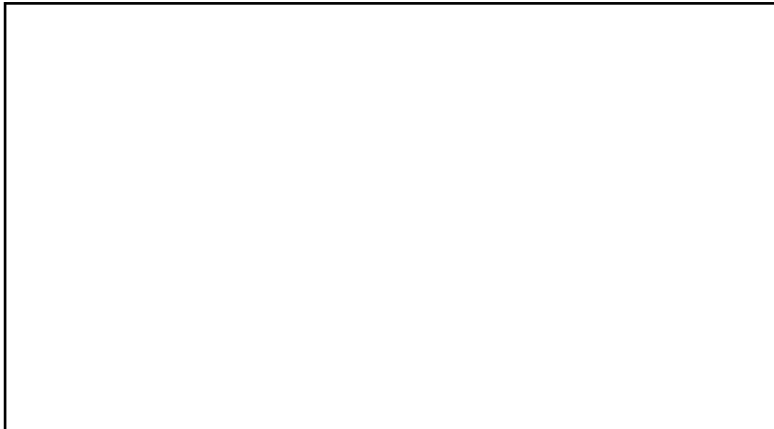
Surgery

Age

Surgery	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations for reasons other than surgeries:

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





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Weight Loss Surgery Questionnaire Packet

Family History

Please answer the following questions regarding your family history.

History includes age or age at death, any medical problems such as diabetes, heart trouble, high blood pressure, stroke, epilepsy, tuberculosis, cancer, and cancer type.

Mother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Father: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Maternal Grandmother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Maternal Grandfather: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Paternal Grandmother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Paternal Grandfather: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____



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Weight Loss Surgery Questionnaire Packet

Spouse: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Son: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Son: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Son: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Daughter: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Daughter: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Daughter: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Other blood relative not listed above:

Relative: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Relative: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Relative: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Relative: Age: _____ Any medical problems: _____

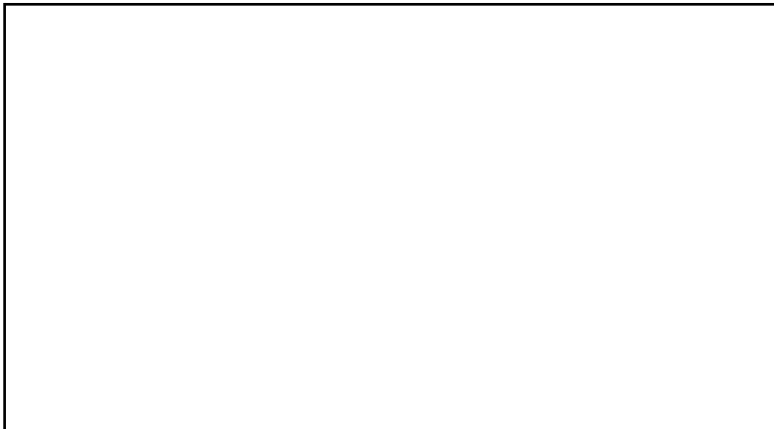
Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Relative: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Relative: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____





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Weight Loss Surgery Questionnaire Packet

Current Medical Condition

Please check yes or no for those that apply.

- High blood pressure Yes No
- On medication Yes No
- Heart disease Yes No
- Diabetes Yes No
- Pulmonary disease/asthma/COPD Yes No
- Seizure disorder Yes No
- Cancer Yes No
- If Yes, what kind: _____
- Depression Yes No
- Mental illness Yes No
- Thyroid problems Yes No
- Gout Yes No
- Hx of transplant Yes No
- If Yes, what kind: _____

Other medical diagnosis (i.e. liver disease):

Please list all current medications, including all over-the-counter pain medication (write down medication name, dosage, frequency, and when taken):



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Weight Loss Surgery Questionnaire Packet

Eyes

- Blurring Yes No
- Double vision Yes No
- Irritation/infections Yes No
- Eye pain Yes No
- Spots or floaters Yes No
- Changes in vision Yes No
- Glasses Yes No
- Contacts Yes No

General

- Fevers Yes No
- Night sweats Yes No
- Chills Yes No
- Fatigue Yes No

Ears/Nose/Throat

- Earaches Yes No
- Discharge from ears Yes No
- Ringing in ears Yes No
- Decrease in hearing Yes No
- Hearing aides - Circle one: Right Left Both
- Recurrent head colds Yes No
- Sinus troubles Yes No
- Dysphagia (difficulty swallowing) Yes No
- Change in taste Yes No
- Change in smell Yes No
- Persistent hoarseness Yes No
- Recurrent sore throats Yes No
- Recurrent sores in mouth Yes No
- Enlarged glands Yes No
- Soreness or bleeding from gums when brushing Yes No
- Dentures - Circle one: Top Bottom Both
- Partials - Circle one: T-B T-B Both
- Permanent bridges or implants Yes No





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Weight Loss Surgery Questionnaire Packet

Cardiovascular

- Chest pain Yes No
- Angina Yes No
- Palpitations Yes No
- Fainting spells Yes No
- Shortness of breath:
 - Walking several blocks Yes No
 - One flight of stairs Yes No
 - When laying down Yes No
 - Wake up at night Yes No
- High blood pressure Yes No
- Swelling of hands or feet Yes No
- Varicose veins Yes No
- Heart disease Yes No
- Circulation problems Yes No
- High cholesterol Yes No

Respiratory

- Cough Yes No
- Cough when lying down Yes No
- Sleep on more than one pillow Yes No
- Shortness of breath Yes No
- Cough up blood Yes No
- Wheezing or asthma Yes No

Sleep apnea diagnosed: _____ Symptoms only no testing: _____

CPAP: _____ Bipap: _____ Other: _____

Skin

- Rashes Yes No
- Lesions Yes No
- Itching Yes No
- Dryness Yes No
- Eczema Yes No
- Psoriasis Yes No

Allergic/Immunologic

- Hay fever Yes No
- Recurrent infections Yes No
- HIV/Exposure Yes No

Endocrine

- Heat intolerance Yes No
- Cold intolerance Yes No
- Hot flashes Yes No
- Brittle nails Yes No
- Change in skin texture Yes No
- Change in hair texture Yes No

Hematologic/Lymphatic

- Abnormal bruising or bleeding Yes No
- Enlarged lymph nodes Yes No
- Blood transfusion or plasma transfusion Yes No





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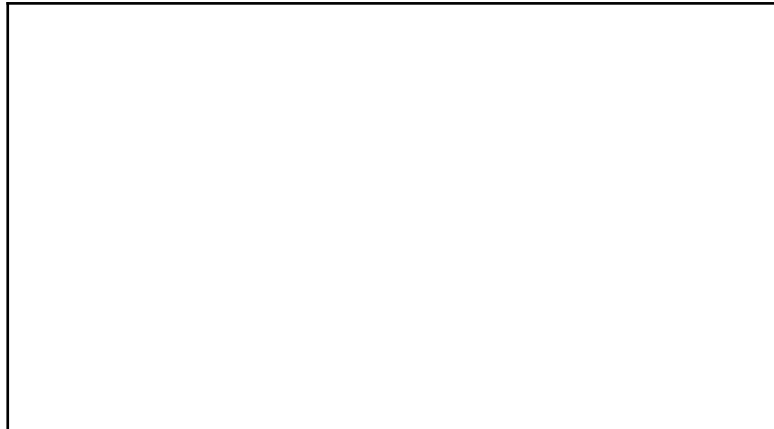
Weight Loss Surgery Questionnaire Packet

Gastrointestinal

- Stomach pain or cramping Yes No
- Heartburn Yes No
- If Yes, how do you treat? _____
- Nausea or vomiting Yes No
- Diarrhea Yes No
- If chronic, has it been evaluated? Yes No
- Constipation Yes No
- If chronic, has it been evaluated? Yes No
- Bleeding from rectum Yes No
- If Yes, has this been evaluated? Yes No
- Vomiting of blood Yes No
- Hemorrhoids Yes No

Genitourinary

- Urinary frequency _____ times per day
- Do you feel like you empty your bladder? Yes No
- Pain with urination Yes No
- Difficulty starting urination Yes No
- Get up at night to urinate Yes No
- Urinate more than before Yes No
- Urinate less than before Yes No
- Blood in your urine Yes No
- Loss of urine with coughing or sneezing Yes No
- Males: Discharge from penis Yes No
- Females: Vaginal discharge Yes No
 - Painful periods Yes No
 - Polycystic ovarian disease Yes No
 - Irregular periods Yes No
- How many pregnancies? _____
 - Live births: _____
 - Still births: _____
 - Miscarriages: _____
 - Cesarean sections: _____





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Weight Loss Surgery Questionnaire Packet

Neurological

- Headaches Yes No
- Migraine headaches Yes No
- Dizzy spells Yes No
- Paralysis Yes No
- Change of sensation in hands or feet Yes No
- Tingling of hands or feet Yes No
- Seizures Yes No
- Tremors Yes No
- Head injuries Yes No
- Knocked unconscious Yes No

Musculoskeletal

- Back pain/backaches Yes No
- If Yes, has it been evaluated? _____
- Joint pain: knees, hips, or ankles Yes No
- Joint swelling Yes No
- Muscle spasms Yes No
- Leg cramps Yes No
- Muscle weakness Yes No
- Stiffness Yes No
- Arthritis Yes No
- Assistive devices: Cane Crutches Walker
- Wheelchair Prosthesis
- Other: _____

Psychiatric

- Depression Yes No
- Have you ever been treated for drugs or alcohol? Yes No
- Dependency: _____
- Anxiety Yes No
- Memory loss Yes No
- Suicidal ideation Yes No
- Attention Deficit Disorder (ADD) or
Attention Deficit Hyperactivity Disorder (ADHD) Yes No
- Bipolar disorder Yes No
- Schizophrenia Yes No
- Paranoia Yes No
- Hallucinations Yes No
- Other: _____





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Weight Loss Surgery Questionnaire Packet

Dieting History Form

Name of diet plan	List year(s) on plan	Wt. loss	Wt. gain	Additional info
Diet (cutting back)				
Liquid diets (Slim Fast)				
Weight Watchers				
Overeaters Annon.				
Tops				
Diet Center				
NutriSystem				
Jenny Craig				
Diet Pills OTC (i.e. Dexatrim)				
Diet Pills Rx				
LA Weight Loss				
Acupuncture				
Hypnosis				
Body Connection				
Optifast				
Medifast				
Atkins (protein diet)				
South Beach				
Mayo Clinic				
Phentermine				
Phen Fen				
Redux				
Herbal tea				
Herbal Life				
Calorie counting				
Fat free diets				
Vegetable diets				
Exercising				
Richard Simmons diet				

How many years have you been obese? _____

Please be specific with when you were on the plan, how much weight you lost and how much gained.

The last 3-5 years are most important.



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Weight Loss Surgery Questionnaire Packet

Epworth Sleepiness Scale

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Name: _____ Date of birth: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the *most appropriate number* for each situation:

0 = would never doze
1 = slight chance to dozing
2 = moderate chance of dozing
3 = high chance of dozing

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3