BluegrassBariatric SURGICAL ASSOCIATES

Transfer of Care

Patient Information Packet

Reason for transfer of care? _____

Are you currently having problems related to your weight loss surgery? ❍ **YES** ❍ **NO**

If yes, please explain: _____

Are you able to read, write and communicate in the English Language? ❍ **YES** ❍ **NO**

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require: _____

_____

Patient Information:

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify

❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____ Your level of Education:_____

What is your height?_____ft _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

Ok to leave message: ❍ Home ❍ Work ❍ Cell

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?_____Relationship to you?_____

Patient Employment Information:

Employment status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ❍ Yes ❍ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?_____ (Month/year)

Spouse's Information:

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information: – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance:

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance:

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact:

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Bluegrass Bariatrics to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s)":

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary Physician:

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Social Media

☐ Other (Please List):_____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

Blood Consent:

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Medical History/Review of Symptoms: (Check all that apply)

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:_____	
Head and Neck:	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:_____
Cardiovascular:	☐ **NONE**	
☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Dyspnea on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:_____

Respiratory: ☐ **NONE**

☐ Asthma ☐ Emphysema / COPD ☐ Bronchitis
☐ Pneumonia ☐ Chronic Cough ☐ Shortness of Breath at Rest
☐ Use of Cpap / Bipap ☐ Use of Oxygen ☐ Snoring
☐ Pulmonary Embolism ☐ Sleep Apnea ☐ Other:_____

Gastrointestinal: ☐ **NONE**

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers
☐ Diarrhea ☐ Blood in Stool ☐ History of Liver Enzymes
☐ Constipation ☐ IBS ☐ Umbilical Hernia
☐ Difficulty Swallowing ☐ Hemorrhoids ☐ Fissure / Polyps
☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia
☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease
☐ Nausea / Vomiting ☐ GERD ☐ Incisional Hernia
☐ Barrett's Esophagus ☐ Other:_____

Bladder/Kidney: ☐ **NONE**

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems
☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?
☐ Trouble starting urine ☐ Burning / Pain on urination ☐ Urinary Urgency/Frequency
☐ Overall Loss of Bladder Control ☐ Other:_____

Gynecologic: (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer
☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain
☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post Menopausal

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast: ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____
☐ Pain ☐ Cancer Date of last Mammogram:_____

Musculoskeletal: ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain
☐ Hip Pain ☐ Wrist Pain ☐ Back Pain
☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain
☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain
☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus
☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis
☐ Fibromyalgia ☐ Other:_____

Neurologic: ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudotumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ("manic-depression") ☐ Seen a Psychiatrist or Counselor

☐ Alcoholism / Substance Abuse ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attention Deficit Disorder ☐ Other:_____

Endocrine: ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ Other:_____

Blood/Lymphatic: ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Other:_____

Skin: ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing

☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea

☐ Hair or Nail Changes ☐ Other:_____

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:		**Taken for what purpose:**		**Dosage/How Often:**	
☐ **Multi Vitamin**	☐ **B1**	☐ **B12**	☐ **Iron**	☐ **Calcium**	☐ **Vitamin D**
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

Allergies: ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

_____

Foods (List foods and the reaction):_____

Social History:

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years do/did you drink alcohol? _____Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

Do you exercise? ❍ Yes ❍ No If yes, times per week? _____

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea ❍ Heart Stopped ❍ Woke up during procedure

❍ Vomiting ❍ Stopped Breathing ❍ Other:_____

❍ Difficulty Waking Up ❍ Difficulty Urinating

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report and all medical records from your previous weight loss surgery ONLY if original surgery was not performed by Bluegrass Bariatrics.)

Date of Surgery:_____ Surgeon: _____

List any complications requiring hospitalization: _____

Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____ ❍ Estimated ❍ Actual

Surgical Procedure(s):	☐ **NONE**	**Year**		**Year**
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____
Hernia: ❍ Hiatal	❍ Umbilical	_____	Back:_____	_____
Tubal Ligation		_____	Knee: ❍ Right ❍ Left	_____
Cesarean Section		_____	Breast Biopsy: ❍ Right ❍ Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Colostomy		_____	Kidney Surgery	_____
Colon Resection		_____	Other:_____	_____
Endoscopy		_____	Other:_____	_____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before sending in your packet:

- ❑ Filled out this form as completely as possible
- ❑ Made a copy of the front & back of your insurance card
- ❑ Signed the Blood Consent
- ❑ Called your insurance and completely filled out the Insurance Review Form
- ❑ **Included a copy of your medical records from your previous weight loss surgery.**

Mail completed Packet and Insurance Card to:

Bluegrass Bariatrics
Attn: Insurance Department
2716 Old Rosebud Road, St. 350
Lexington, Kentucky 40509
Phone: 859-543-1577
Fax: 859-543-1637

Date Completed: _____

BluegrassBariatric
SURGICAL ASSOCIATES

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery and if your follow up care will be covered. Please follow the instructions below. **This form does not need to be completed for Medicare but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. **Do not leave any fields blank.**
5. **Sign the form on the back. Failure to do so will result in the form being returned.**
6. Once complete, return this form, along with a copy of your insurance card(s), to our office.
7. Please also make sure that you submit your patient profile packet via mail or internet.
8. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
    a. Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. **You must complete this form if you have a Medicare supplement plan, Medicare Replacement plan, or a Medicare HMO.**

Fill in this information before you call the insurance company. Please write clearly.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	□ **Yes** (Continue with this form.) □ **No** (Complete #s 2 & 17 through 20 then end the call.) **See explanation below
****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. An exclusion can result in follow up care not be covered.**		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3	Do I have a Bariatric Lifetime Maximum?	

4	Is Bluegrass Bariatrics in my network? Tax ID#: 161661481	
5	What is the effective date of my policy?	
6	What is the calendar year renewal date?	
7	Do I have a pre-existing clause?	
8	If yes, what is the end date of the pre-existing clause?	
9	Is a referral required?	
10	What is the deductible per calendar year?	
11	How much have I met towards my deductible?	
12	What is the maximum out of pocket per calendar year?	
13	How much have I met towards my maximum out of pocket?	
14	Is the deductible applied to the maximum out of pocket?	
15	What is the co-insurance percent for my policy?	
16	What is my copay for a primary care office visit?	
17	What is my copay for a specialist office visit?	
18	Name of the representative	
19	Date you spoke to representative	
20	**If you have an exclusion in your policy, would you like to self pay for follow up care that is not covered by your insurance? If yes, we will proceed with your process. If no, your process will be stopped.**	**□ Yes** **□ No**

Disclaimer:

- Bluegrass Bariatrics is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**
- **I have read and understand the above disclaimer.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

Patient Signature: _____ **Date:** _____