

INFORMED CONSENT FOR LAPAROSCOPIC SLEEVE GASTRECTOMY SURGICAL PROCEDURE

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

Patient's Initials or Authorized Representative

Date

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

I, _____, hereby authorize Dr. _____ and any associates or assistants the doctor deems appropriate, to perform Laparoscopic Sleeve Gastrectomy surgery. The doctor has explained to me the risks of obesity and the benefits of a Laparoscopic Sleeve Gastrectomy; however, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

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

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

Pre-operative Requirements. I have completed the Physician-Supervised Multidisciplinary Program, which included Dietary Therapy - a discussion of dietary history and a nutritional visit by either a physician or dietitian and supervised dietary therapy, as well as Physical Activity, and Behavior Therapy/Support Groups. Since the time of my initial evaluation to the date of surgery, I have either maintained my weight or have lost weight.

Post-operative Requirements. I agree to participate in post-surgical follow-up visits at intervals of one to 3 weeks for the first 3 months after surgery, then at 6 months post-surgery, 9 months post-surgery, and annually for life thereafter with my surgeon or someone designated by my surgeon. I also agree to follow a multi-disciplinary program post-surgery as suggested by my surgeon or other designated physician which may include diet, physical activity, and behavior modification.

Proposed Procedure. I understand that the procedure that my surgeon or surgeons have recommended for the treatment of my obesity is the Laparoscopic Sleeve Gastrectomy. My surgeon or surgeons have provided a detailed explanation of the medical history of the development of the surgical treatment of obesity, the sleeve gastrectomy as a treatment for obesity and the development of laparoscopic (minimally invasive) surgery. I have been strongly encouraged to make every effort to investigate and understand the details of the operation.

I understand the nature of the Sleeve Gastrectomy will be done laparoscopically and entails the use of a fiber optic endoscope along with special endoscopic instruments and staplers to facilitate completing the procedure with smaller incisions than in an open approach. I understand that the Laparoscopic Sleeve Gastrectomy is an acceptable option as a primary bariatric procedure and as a first-stage procedure in high risk patients as part of a planned staged approach.

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

1. Abscess
2. Adult Respiratory Distress Syndrome (ARDS)
3. Allergic reactions
4. Anesthetic complications
5. Atelectasis
6. Bleeding, blood transfusion, and associated risks
7. Blood clots, including pulmonary embolus (blood clots migrating to the heart and lungs) and deep vein thrombosis (blood clots in the legs and/or arms)
8. Bile leak
9. Bowel obstruction
10. Cardiac rhythm disturbances
11. Complications in subsequent pregnancy (no pregnancy should occur within the first year after surgery)
12. Congestive heart failure

13. Dehiscence or evisceration
14. Depression
15. Dumping syndrome
16. Death.
17. Encephalopathy
18. Esophageal, pouch or small bowel motility disorders
19. Gout
20. Hernias, incisional (including the port sites for laparoscopic access) and internal
21. Inadequate or excessive weight loss
22. Infections at the surgical site, either superficial or deep including port sites for laparoscopic access. These could lead to wound breakdowns and hernia formation.
23. Injury to the bowels, blood vessels, bile duct, and other organs
24. Injury to adjacent structures, including the spleen, liver, diaphragm, pancreas and colon
25. Intestinal leak
26. Kidney failure

27. Kidney stones
28. Loss of bodily function (including from stroke, heart attack, or limb loss)
29. Myocardial infarction (heart attack)
30. Need for and side effects of drugs
31. Organ failure
32. Perforations (leaks) of the stomach or intestine causing peritonitis, subphrenic abscess or enteroenteric or enterocutaneous fistulas
33. Pleural effusions (fluid around the lungs)
34. Pneumonia
35. Possible removal of the spleen
36. Pressure sores
37. Pulmonary edema (fluid in the lungs)
38. Serious intra-abdominal infection such as sepsis or peritonitis
39. Skin breakdown
40. Small bowel obstructions

41. Staple line disruption

42. Stoma stenosis

43. Stroke

44. Systemic Inflammatory Response Syndrome (SIRS)

45. Ulcer formation (marginal ulcer or in the distal stomach)

46. Urinary tract infections

47. Wound infection

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

1. Protein malnutrition

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

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

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

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

1. Depression

2. Bulimia

3. Anorexia

4. Dysfunctional social problem

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

1. Adverse outcomes may be precipitated by smoking

2. Constipation

3. Diarrhea

4. Bloating

5. Cramping

6. Development of gallstones

7. Intolerance of refined or simple sugars, dumping with nausea, sweating and weakness

8. Low blood sugar, especially with improper eating habits

9. Vomiting, inability to eat certain foods, especially with improper eating

habits or poor dentition

10. Loose skin

11. Inter-triginous dermatitis due to loose skin

12. Malodorous gas, especially with improper food habits

13. Hair loss (alopecia)

14. Anemia

15. Bone disease

16. Stretching of the pouch or stoma

17. Low blood pressure

18. Cold intolerance

19. Fatty liver disease or non-alcoholic liver disease (NALF)

20. Progression of pre-existing NALF or cirrhosis

21. Vitamin deficiencies some of which may already exist before surgery

22. Diminished alcohol tolerance

d. Pregnancy complications were explained as follows:

1. **Pregnancy should be deferred for 12 to 18 months after surgery or until the weight loss is stabilized**
2. **Vitamin supplementation during the pregnancy should be continued**
3. **Extra folic acid should be taken for planned pregnancies**
4. **Obese mothers have children with a higher incidence of neural tube defects and congenital heart defects**
5. **Pregnancy should be discussed with an obstetrician**
6. **Special nutritional needs may be indicated or necessary**
7. **Secure forms of birth control should be used in the first year after surgery**
8. **Fertility may improve with weight loss**

Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. I also understand that some or all of the complications listed on this form and also explained to me may exist whether the surgery is performed or not, in that sleeve gastrectomy surgery is not the only cause of these complications.

Alternative Procedures. In permitting my doctor to perform this procedure, I understand that unforeseen conditions may necessitate change or extension of the original procedure(s), including completing the operation by way of the conventional open surgical approach, or a different procedure from what was explained to me.

CERTIFICATION OF PHYSICIAN:

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

Date Time Signature of Physician

USE OF INTERPRETER OR SPECIAL ASSISTANCE

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

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____

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

Signature (Individual Providing Assistance) Date Time

Patient Responsibilities

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

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

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

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

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

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

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

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

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

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

_____ I agree to see my surgeon and family physician as directed.

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

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

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

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

Patient Name _____ (printed)

Patient Signature _____ Date _____

WITNESS:

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

Witness Name _____ (printed)

Witness Signature _____ Date _____

USE OF INTERPRETER OR SPECIAL ASSISTANCE An interpreter

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

- _____ Foreign Language (specify)
- _____ Sign Language
- _____ Patient is blind, form read to patient
- _____ Other (specify) _____

Interpretation provided by _____

Fill in name of interpreter and title or relationship to patient

Signature (Individual providing assistance)

Date

GUIDELINES FOR YOUR BARIATRIC SURGERY

NSAIDS (Non-Steroidal Anti-Inflammatory)

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

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

STEROIDS

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

DIURETICS (WATER PILLS)

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

TRAVEL

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

HERBAL SUPPLEMENTS

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

PREGNANCY

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

Patient Signature

Date

Witness Signature

Date

Smoking, Bariatric Surgery and YOU!

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

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

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

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

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

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

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

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

- ACS Guide to Quitting Smoking
- ACS Quit Smoking Tips

Patient's Signature

Alcohol Consumption after Gastric Bypass

Does Gastric Bypass Alter Alcohol Metabolism?

Surgery for Obesity and Related Diseases. Volume 3. Issue 5. Pages 543-548 J Hagedom. B. Encarnacion. G. Brat. J. Morton.

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

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

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

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

Patient's Signature

Witness Signature

Date

Patient Contract

Understanding pregnancy, fertility and bariatric surgery

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

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

_____ 1. I understand that one of the goals of the Patient Contract is to help my bariatric team Members understand that I commit to avoid pregnancy until discussed and cleared with my surgeon and obstetrician.

_____ 2. I understand and agree that pregnancy should not be attempted until weight loss and nutritional intake have stabilized.

_____ 3. As a woman of childbearing age who seeks bariatric surgery, I commit to using two reliable birth control methods during the period of rapid weight loss.

_____ 4. I understand that maternal malnutrition may impair normal fetal development.

_____ 5. When I become pregnant, I understand the importance of prenatal vitamins and other supplements and agree to take the prescribed amounts prior to and for the entire pregnancy as recommended by my dietician or obstetrician.

_____ 6. I expect to delay pregnancy for at *least* 18 months after surgery

_____ 7. I agree to discuss my procedure, the need for birth control, and my commitment to avoid pregnancy with my significant family members.

_____ 8. When I become pregnant, I can expect that my surgeon and obstetrician will order special testing and treatments that could result in additional costs.

_____ 9. I understand that I must stop all birth control (oral pills, patches, injections, implants, vaginal rings) one month before surgery and will not resume them until one month after surgery. Use extreme caution during this time and use reliable method of birth control to prevent pregnancy. The use of condoms, although not 100% effective, is the most reliable. A diaphragm is acceptable, but must be continuously adjusted with weight loss.

Date	Time	Signature of patient or authorized representative	relationship
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WITNESS:

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

Venice Metabolic and Bariatric Surgery

Pain Medication Policy

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

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

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

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

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

Sincerely,

The Team at Venice Metabolic and Bariatric Surgery

Patient Signature and Date

Spousal Agreement

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

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

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

Dated at _____ this _____ day of _____, —

Spouse signature: _____

Printed Name: _____

Witness Signature: _____

Printed Name:

Can also be used by Significant Other

Advocate Support Agreement

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

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

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

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

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

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

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

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

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

Advocate Signature _____

Printed Name _____

Witness Signature _____

Printed Name _____

Patient Contract **Vitamin and Protein Supplements**

_____ 1. I understand that Roux-en-Y Gastric Bypass is both malabsorptive and restrictive; if I do not take the recommended vitamin/mineral supplements, I may develop vitamin/mineral deficiencies.

_____ 2. I understand that my bariatric surgery team may ask me to keep a food journal/diary to help assess nutritional problems, protein/vitamin intake or disordered eating behavior.

_____ 3. I can expect nutritional lab work done at least annually for the rest of my life, and it is my responsibility to have this done as directed.

_____ 4. I understand the importance of a balanced diet including protein which promotes satiety (fullness) and protects muscle mass during active weight loss.

_____ 5. I agree to take the recommended vitamin/mineral supplementation regimen recommended by my team which typically includes: multivitamin, vitamin B12, calcium citrate, vitamin D, (and others as indicated by deficiencies found on my lab work).

_____ 6. I agree to work on eating habits/behaviors before surgery to optimize my weight loss and nutrition, and will need to pay attention to my eating habits/behaviors for life.

_____ 7. If my lab work shows vitamin/mineral deficiencies before surgery, I may need to repeat these levels before having surgery to optimize my health.

_____ 8. It is my responsibility to ask questions when I am uncertain about vitamins and protein supplements.

_____ 9. I understand that if I fail to accept my responsibility for care as directed by the team, I could be terminated from their care.

- The Patient/Authorized Representative has read the entire form or had it read to

Date

Time

Signature of Patient or Authorized Representative

him/her.

- The Patient/Authorized Representative has express understanding of this form.
- The Patient/Authorized Representative has no further questions.

Date

Time

Witness Signature

Vitamin and Protein Supplements Test

True False

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

Authorized Representative

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

Date

Time

Witness Signature

Signature of Patient or