The Maryland Bariatric Center AT MERCY

Kuldeep Singh, M.D., FACS, MBA, FASMBS

250 N. Calvert St, Baltimore, MD
7625 Maple Lawn Blvd, Fulton, MD

Phone: 410-332-9528 / Fax: 410-385-9383
Email: Bariatrics@mdmercy.com
www.MDMercy.com/Bariatrics

THIS PACKET NEEDS TO BE RECEIVED BY THE OFFICE, AT LEAST 3 DAYS PRIOR TO YOUR APPOINTMENT, IF NOT RECEIVED YOUR APPOINTMENT IS SUBJECT TO RESCHEDULING AND CANCELATION. PLEASE CALL TO VERIFY RECEIPT.

PATIENT'S AUTHORIZATION

I,_____, hereby authorize Kuldeep Singh, M.D., to apply for benefits for covered services rendered by Kuldeep Singh, M.D., and request that the payments from:

_____

(Patient's Insurance Carrier)

be made directly to Kuldeep Singh, M.D., I certify that the information I have reported with regard to my insurance coverage is correct and I further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time, by written request.

_____ _____
Signature of Subscriber or Beneficiary Date

PATIENT REGISTRATION – PLEASE PRINT CLEARLY **ALL SPACES MUST BE COMPLETED**

Patient's Name:
First _____ Middle _____ Last _____

Address_____ Male ( ) Female ( ) Race_____

City _____ State _____ Zip_____

Home Ph#_____Work Ph#_____Cell# _____

Email Address: _____

Date of Birth:_____Weight:_____Height: _____

Employer's Name _____

PRIMARY CARE PHYSICIAN

FULL NAME _____

ADDRESS _____

PHONE #_____ FAX # _____

INSURANCE INFORMATION: PLEASE HAVE CARD AVAILABLE FOR COPYING

Insurance _____

Address _____

Policy ID #_____ Group #_____

Subscriber's name_____ Subscriber's DOB_____

Today's Date:_____ Height:_____ Weight: _____

Name:_____ Birth date: _____

Employment status: Full Time Part Time Unemployed Retired

I am interested in ***Please circle one*****:** Sleeve Gastrectomy Gastric Bypass Unsure

Have you ever been to see us before for a consultation? Yes No

PATIENT HISTORY FORM:

Knowing your detailed medical history information is very important for our assessment of your health. Obesity and its associated diseases and risk factors increase mortality and surgical complications. **We rely on the information you provide; therefore it is imperative for safety and insurance purposes that a detailed medical history be performed.**

I am also aware of the following:

- **NO tobacco products are permitted for 8 weeks before surgery- this gives your lungs a chance to better provide oxygen to your blood, which can help decrease the risk of infection, pneumonia, and especially improve wound healing.**
- Second hand smoke is also irritating to the lungs.
- **We will not operate on any patient that is an active smoker and may require you to take a laboratory test that confirms you are smoke free.**

PATIENT STATEMENT

I am aware that bariatric surgery is not a "quick fix" but rather a tool for controlling weight, combined with exercise and proper nutrition. I am aware that I will be expected to follow up post op on a regular basis, and be required to take vitamins, and supplements for the rest of my life. I am also aware that reversal of this surgery is not recommended. The information on my medical history form is true and correct to the best of my belief.

_____

Patient's signature

_____

Date

WEIGHT LOSS HISTORY

YOUR NAME_____

Most insurance companies require documented evidence of previous weight loss attempts so it is critical that you fill this out in detail. Please include dates as well as length of time of each diet, to the best of your knowledge.

What weight loss attempts have you made in the past? _____

_____

What was the timeframe? _____

Have you completed a recent diet for this visit? _____

What was your best weight loss with dieting? _____

REVIEW OF MEDICAL PROBLEMS (Please check and/or explain any of the items listed)

CARDIOVASCULAR

- ☐ Heart problems _____
- ☐ Chest pains _____
- ☐ Previous Heart Attack _____
- ☐ High blood pressure _____
- ☐ Previous Blood Clot or PE _____
- ☐ Shortness of Breath _____
- ☐ SOB while exercising _____
- ☐ High cholesterol _____
- ☐ High triglycerides _____
- ☐ Feel tired all the time _____

DIABETES AND ENDOCRINE SYSTEM

Diabetes Mellitus (Type 1 or 2)

When was your diabetes first diagnosed? _____

How long have you been taking oral agents? _____

How long have you been taking insulin? _____

Does your diabetes resolve with weight loss? _____

Pre-diabetic

(Abnormal glucose tolerance test)

Gestational _____

Age of diagnosis _____

Hypoglycemia _____

Thyroid problems (requiring medication) _____

GASTROINTESTINAL

Gallbladder Problems

Do you have gallstones diagnosed by ultrasound? _____

Have you had your gallbladder removed open or laparoscopically? _____

Stomach Ulcers

Have you taken medicine for ulcers? _____

Heartburn

How often do you have heartburn and do you take medications for it? _____

RESPIRATORY

Asthma *YES or NO*

Last attack? _____

COPD *YES or NO*

Last attack? _____

Bronchitis *YES or NO*

Last attack? _____

Pneumonia *YES or NO*

Last attack? _____

Blood clots in lungs? _____

Blood clots in legs? _____

Smoking History

Starting age? _____

What **YEAR** did you stop? _____

How many packs per day? _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times.

Use the following scale to chose the most appropriate number for each situation.

0= would never doze

1= slight chance of dozing

2= moderate chance of dozing

3= high chance of dozing

Situation	**Chance of dozing**
Sitting and reading……	
Watching TV ……	
Sitting, inactive, in a public place (e.g. a theater or a meeting)……	
As a passenger in a car for over an hour without a break…….	
Sitting and talking to someone……...	
Sitting quietly after lunch without alcohol…….	
In a car, while stopped for a few minutes in traffic……	
Total……	

Score: 0-10 Normal Range
10-12 Borderline
12-24 Abnormal

Previous Sleep Study or do you have one scheduled? Yes No

Do you currently use or have you previously been prescribed a CPAP or BiPAP machine? Yes No

MUSCULOSKELETAL

	MILD	**MODERATE**	**SEVERE**
Hip pain			
Knee pain			
Ankle pain			
Feet pain			
Back pain			
Neck pain			
Arthritis			

Musculoskeletal continued

Are you using anti-inflammatory or pain medicine? _____
Do you have swelling of your legs? _____
Do you have swelling of your feet? _____
Do you have varicose veins? _____
Have you had ulcers of the leg? _____

KIDNEY & BLADDER

Do you have renal insufficiency or failure? _____
Have you had bladder or kidney infections? _____
Have you had kidney stones? _____

Musculoskeletal continued

BLOOD

Have you ever had a bleeding problem? _____

Have you ever had low platelets? _____

Have you ever had a blood transfusion? _____

NEURO-PSYCHIATRIC

Depression/Anxiety _____

Because of obesity? _____

Requiring medication? _____

Seizures _____

Requiring Medication? _____

Severe headaches? _____

Requiring Medication? _____

Visual problems? _____

Been in counseling? _____

History of alcohol abuse? _____

How long have you been sober? _____

History of drug abuse? _____

How long have you been clean? _____

Eating disorder? _____

Bulimia? _____

Anorexia Nervosa? _____

ALLERGIES

Do you have any allergies to medicine? (Please list) _____

If so, what was the reaction? _____

Do you have any allergies to food? (Please list) _____

If so, what was the reaction? _____

Have you ever had reaction to anesthesia or has a family member had a reaction? Yes No

Are you allergic to Latex products? Yes No

PAST SURGICAL HISTORY

We need a complete list of all your previous surgeries. Please list the type of surgery below:

Tonsillectomy YEAR _____

Cholecystectomy (gallbladder removal) YEAR _____

Appendectomy YEAR _____

Hysterectomy (removal of uterus) YEAR _____

Cesarean Section (C-section) YEAR _____

Oophorectomy (removal of ovary) YEAR _____

Previous Bariatric Surgery (CIRCLE ONE) Yes No If yes, with who?_____

Where performed? _____When?_____

Top Weight_____Low Weight_____

Hiatal Hernia surgery_____ _____

Cardiac Surgery (CIRLE ONE) Yes No

Other Surgeries :_____

HABITS

Do you consume alcohol and if so how much? _

Any other habits that you have? _____

MEDICATIONS (Report **name, dose, and frequency** and what you are taking it for)

MEDICATION	DOSAGE	FREQUENCY	CONDITION

SOCIAL

Are you employed? Full Time Part Time Retired Homemaker Unemployed Employer_____

Describe your work and home life (family members, etc)

_____

_____

_____

_____

_____

_____

_____

Name a close, supportive friend or family member who I can talk to:

_____

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

	Mother	Father	Sibling	Aunt/Uncle	Grandparent
Obesity					
Diabetes					
Heart disease					
High blood pressure					
Cancer					
Arthritis					
Early death					
Cause					

Has any member of your family suffered from Blood Clots or Pulmonary Embolism? Yes No

If yes, please describe:

_____

_____

How did you hear about us?

_____

FOR WOMEN ONLY

Have you ever been diagnosed with polycystic ovarian syndrome? Yes No

Have you had problems conceiving? _____

How many pregnancies have you had? _____

How many children do you have/ _____

Any pain with period? _____

The Maryland Bariatric Center AT MERCY

Patient's Name: _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during the day?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35 (kg/m2)?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

_____ High risk of OSA: Yes 5-8

_____ Intermediate risk of OSA: Yes 3-4

_____ Low risk of OSA: Yes 0-2

Mercy
MEDICAL CENTER
BALTIMORE, MD 21202

BARIATRIC OPIOID / NARCOTIC PRESCRIPTION POLICY

Patient Identification

Dear Patient,

We are grateful that you are pursuing the treatment of your obesity at The Maryland Bariatric Center at Mercy. During the normal course of your care, it may be necessary to utilize opioid/narcotic pain medications. You may be aware of the growing health and societal concerns related to opioids. In an effort to optimize your care, we have developed policies for the prescription of opioid pain medications to our patients. This notice is to inform you of these policies.

Signing this document means that you intend to allow only The Maryland Bariatric Center at Mercy to provide you with whatever post-operative opioid pain medications may be appropriate and not to obtain any opioid pain medications from another practice/provider during the duration of your post-operative period as defined below.

Duration:
The Maryland Bariatric Center at Mercy will provide opioid pain medications for pain control for up to four weeks after bariatric surgery. During your early post-operative visits, we will work with you and guide you in the appropriate weaning from and cessation of opioid pain medications. There are non-opioid medications available to you that will aid you during the post-operative period.

We understand that every patient is different and has variable pain intolerance. Once you reached your fourth week of your post-operative period, you will not be given any additional opioid pain medications, unless you have medical reasons, such as complications from surgery.

If you are on chronic pain medications, please note that your pain management provider should be giving you your prescriptions after four weeks of surgery. **Non-availability of your pain management provider will not be an acceptable reason to ask us for chronic pain medications, and your request will not be honored.**

Refill Policy:
Refills on any opioid pain medications will only be provided during an office visit or during regular office hours. No refills of opioid pain medications will be provided during the evenings or over weekends through our on call answering service. We encourage you to anticipate when you may run out of medication and contact us with sufficient notice to obtain a refill prescription.

If you are prescribed opioid pain medication after a surgical procedure, **please be advised that we will not replace lost, stolen or misplaced prescriptions.** You are responsible for the prescription once the provider has given it to you.

If a refill is requested after the fourth week, you will be referred to your primary care or pain management provider for additional care to manage your pain.

Thank you for your cooperation.

Please sign and date below to acknowledge your agreement, compliance and understanding of this policy.

Patient Signature	Patient Name (Print)	Date	Time

NARCPRESLTR

Kuldeep Singh, M.D.
The Maryland Bariatric Center at Mercy
250 N. Calvert St.
Baltimore, MD 21202
Phone: 410-332-9528 Fax: 410-385-9383

Steps to Receive Authorization

Insurance: _____

- Supervised Weight Loss/Diet (*contact your insurance to see how many months are needed*)
  OR
- New Tri for 90 days **$149.99 out of pocket expense** (Please note, all insurances do not accept New Tri. Check with your insurance company to confirm coverage)*
- Psychological Exam
- Nutrition Consult

Once ALL of the above steps have been completed please call the surgical coordinator to start your submission to the insurance company.

Psychologist

Mary Rouse - (Self Pay) 301-938-1634

- See additional sheet for more Psychologist options

Dieticians

Kristian Morey – (Billed through insurance) 410-659-2833
Leigh Tracy – (Billed through insurance) 410-385-3267
Marta Ferraz Valles – (Self Pay) 410-332-9356

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Getting Submitted For Surgery

Please notify the surgical coordinator once you feel that you have completed your process.
Please note without the diet, psych evaluation and nutrition we are unable to submit you to your insurance company.
Once you are submitted for surgery the surgical coordinator will contact you when a decision has been received, allow her to contact you. **Repeat calls will only delay the process further.**

Please note that we are unable to appeal any decisions that are made for lack of bariatric coverage.
Once you are approved for surgery you will be scheduled for the next available appointment to see Dr. Singh if you have not seen him within 3 months. There is no way around this and you will be unable to be rescheduled if you cancel or do not show up for your appointment.

Surgery will be scheduled for the first available date (2 weeks from date of call from the Surgical Coordinator stating you are approved), if that date is not workable for your schedule we will need to decide on one that is (within a 4-week span), **Surgeries will not be rescheduled** after they have been scheduled, unless there is an emergent need.

FMLA

FMLA and Short-Term Disability paperwork has a **$25.00 fee**. In order to have this paperwork completed. Please get the papers from your job's Human Resources Department and send them to the Surgical Coordinator. In order to expedite the process, including the type of work you do and the time you expect to be out of work.

PLEASE NOTE THAT FOR JOBS WITH LOW PHYSICAL ACTIVITY WE WILL WRITE YOU OUT FOR THREE WEEKS THEN SEND YOU BACK TO WORKS FOR THE REMAINING THREE WEEKS ON RESTRICTIVE DUTY. RESTRICTIVE DUTY MEANS THAT YOU MAY NOT LIFT, PULL, OR PUSH MORE THAN 20 LBS.
Please allow at least **5 business days to have paperwork completed** if you need paperwork sooner please make sure you have paid for the process and notified the Surgical Coordinator. 24-hour notice is not an adequate timeframe.

We love hearing from each one of our patients. We would like to be able to assist everyone in a timely fashion. In order to do so, please make sure that you refer to this packet before calling with questions.

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MONTHLY PHYSICIAN SUPERVISED DIET PROGRAM

VISIT #: 1 2 3 4 5 6 7 (Please circle)

NAME: _____ DOB: _____

DATE OF EXAM: _____

TODAY'S WEIGHT: _____ HEIGHT: _____

DIET REGIMEN: _____

EXERCISE REGIMEN: _____

_____

PROGRESS: _____

_____

RECOMMENDATIONS: _____

_____, M.D. _____
PHYSICIAN SIGNATURE PRINTED NAME

GUIDELINES:

Your patient's insurance company requires written documentation of a monthly supervised diet before they will authorize bariatric surgery in accordance with Maryland insurance regulations. **This diet may be either 3, 6 or 7 consecutive months of diet or two diets lasting three consecutive months and must be documented within the past 2 years.**

If patient progress is not documented or if they "skip or miss" a month the insurance company will require them to start the process over again. THERE ARE NO EXCPETIONS TO THIS REQUIREMENT. No insurance company will accept a summary letter. All visits must be documented as listed above. This form may be duplicated for the monthly requirement to ensure all the information is complete.

If you have any questions please contact the office at 410-332-9528.

When the diet is completed please fax all forms to the office at 410-385-9383. Please contact us after you have faxed the information to confirm receipt of these documents. We are not responsible for any documents that are lost in the mail. It is the patient's responsibility to make sure that we have all documentation to submit for authorization. Thank you.

Below you will find some Psychologist Options – you may chose someone outside this list. We do recommend that they have experience with Bariatric Surgical Candidates

GBCC
GREATER BALTIMORE
COUNSELING CENTER, LLC

open path
psychotherapy collective

BariatricPsychAssessment.com

SANIHA H. MAKHZOUMI, PH.D.
CLINICAL PSYCHOLOGIST

CORE
COUNSELING

Home > Our Counselors

Counseling Center
For Change
"change begins today"

The Maryland Bariatric Center AT MERCY

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INFORMATION FOR YOUR PSYCHOLOGICAL CLEARANCE

All patients need a psychological clearance as recommended by the American Society for Bariatric Surgery. This can be done by a local psychologist or psychiatrist, or we can refer you to one. We also want to be sure you understand the implications of the surgery and that you have a good support system of friends and family. Bring a copy of the enclosed questionnaire with you when you go to the therapist. Also bring the attached letter to the psychologist to help guide him or her with the assessment. It is helpful if you try to answer these questions for your psychologist. It is always best if you see a psychologist prior to your office appointment. This note will help us expedite the authorization process. **Please contact the office if you need the name and location of a psychologist.**

To your psychologist, psychiatrist, LCSW or Nurse Practitioner:

Our mutual patient is considering surgical weight reduction and requires an evaluation by a psychologist or psychiatrist. Both the insurance companies and the surgeons require this. Most insurance companies will not authorize the surgery without a letter of support from a licensed therapist. It is helpful if you provide documentation on the following issues:

1. How does the patient think surgery will help?
2. How long has obesity been a problem?
3. Please list and describe some sources of stress in the patient's life.
4. Please provide details of the patient's personal history such as where he/she is from, where he/she lives now, education, marital status, home situation and family interactions, physical and sexual abuse.
5. Provide details of tobacco, alcohol and recreational drug use. Any history of addictions / substance abuse?
6. Any significant untreated or incompletely treated psychiatric illness?
7. Provide details of depression, suicidal tendencies, eating disorders and compliance issues.
8. Provide details of comprehension of the surgery and the ability to make lifestyle changes.
9. Provide details of compliance in diet, exercise, lifelong vitamins and follow up.
10. Is the patient reliable? Will he/she be compliant with postoperative instructions?
11. Does the patient understand that non-compliance puts the patient at risk for complications?
12. Does the patient have realistic expectations and understand that numerous complications can occur?
13. Does the patient have adequate support?
14. Is the patient capable of giving informed consent?

Neuro-Psychiatric:
Depression? Because of obesity? Requiring medication?
Seizures? Requiring medication?
Severe headaches? Requiring medication?
Visual problems?
Been in counseling?
History of alcohol abuse? How long have you been sober?
History of drug abuse? How long have you been clean?
Eating disorder? Bulimia? Anorexia Nervosa?

Social: Describe the patient's work and home life (family members, etc).

Sincerely, The Maryland Bariatric Center at Mercy

Please mail or fax the report to our office: 410-385-9383.