701 West Front Street, Suite 200
Traverse City, MI 49684
Phone (231) 346-4014
Fax (231) 932-7311

ROCHE J. FEATHERSTONE, M.D.
MICHAEL A. NIZZI, D.O.
STEVEN E. SLIKKERS, M.D.
DAVID M. KAM, M.D.
ASHLEY SACHTLEBEN, D.O.
MARY KAY WILLIAMS, MSN, FNP-C.

Dear Sir/Madame:

Thank you for your inquiry concerning Bariatric (weight loss) surgery for severe obesity. Grand Traverse Surgery offers Roux-en-Y Gastric Bypass, Vertical Sleeve Gastrectomy and Biliopancreatic Diversion with Duodenal Switch as surgical options for weight loss.

Bariatric surgery has been endorsed by the National Institutes of Health as the only effective means of accomplishing significant long-term weight loss for most severely obese patients. The Roux-en-Y Gastric Bypass procedure is currently considered the standard of care for long-term weight loss management. The Vertical Sleeve Gastrectomy and the Biliopancreatic Diversion/Duodenal Switch are alternate options offered for selected individuals.

To be considered for these procedures:

1. You must be between 18 and 70 (over 70 considered on a case by case situation)
2. You must have at least a body mass index (BMI) of greater than 35 with one or more obesity related conditions or a BMI of 40 or higher with no medical conditions.
3. Your medical record must show that efforts to treat your condition medically or psychologically have been unsuccessful.
4. Your family physician must have recommended this procedure.
5. You must be willing to commit to long-term follow up and be compliant with recommendations.

If you think you are a candidate for Bariatric surgery, please complete the enclosed patient information packet and be prepared to hand it in at the end of the educational seminar.

Sincerely,

Roche J. Featherstone, MD
Michael A. Nizzi, DO
Steven E. Slikkers, MD
David M. Kam, MD
Ashley Sachtleben, DO
Mary Kay Williams, FNP-C

Obtaining the Required Referral

Based upon the requirements of insurance carriers, all patients must have a referral letter from their Primary Care provider (PCP) prior to making a consult visit.

The letter should document the following:

1. A statement that you suffer from clinically severe obesity. *(ICD-9 code 278.01)*

2. A statement that, in his or her medical opinion, you would benefit from having surgery for the treatment of your obesity.

3. A list of the various treatments and diets that you have tried in the past, including any dietary therapy, physical exercise, behavioral therapy, counseling, or pharmacotherapy, etc.

   IF THE INSURANCE CRITERIA REQUIRES **SIX CONSECUTIVE MONTHS** OF A WEIGHT MANAGEMENT PROGRAM WE NEED EACH PROGRESS NOTE FAXED TO US WITH THE REFERRAL LETTER FROM THE PRIMARY CARE DOCTORS OFFICE.

4. Any associated medical problems and the medications/treatments that they require.

5. Height and weight at your last office visit.

This letter from your PCP is essential in order to obtain approval from your insurance carrier for this surgery. Please have the letters sent to:

Grand Traverse Surgery, P.C.
ATTN: Bariatric Department
701 W. Front Street, Suite 200
Traverse City, MI 49684

Or faxed to: (231) 932-7311

If you have questions or need assistance in obtaining this letter, please call our office at **(231)346-4014.**

Patient Checklist - Education Seminar & Consultation

This checklist will help you ensure you have the necessary forms ready for the Education Seminar and your first weight loss surgery appointment. Please allow two hours for the Education Seminar and most of the day for your appointment, as you will be meeting several members of our staff. We look forward to meeting you in person and answering your questions.

Educational Seminar

Please allow two hours for the Education Seminar.

☐ **Seminar Date:** _____
Seminar Time: 6 - 8 pm
Seminar Location: _____

☐ **Completed Patient information packet**

Consultation Appointment

Please allow most of the day for your consult appointment.

☐ **Consult Date:** _____
Consult Time: _____
Consult Location: Grand Traverse Surgery
701 West Front Street, Suite 200
Traverse City, MI 49684

☐ **If needed, an insurance pre-auth for your consultation appointment by your primary care physician**
☐ **Bring insurance card**
☐ **Bring Picture ID**
☐ **Office Co-Pay will be collected at time of service**

☐ **History & Physical Examination report from your Primary Care Physician including:**

1. Height/weight
2. Listed medical problems/co-morbidities such as:
    a. Sleep apnea
    b. Hypertension
    c. Diabetes
    d. Acid reflux
    e. Fen-Phen or Redux use/duration
3. If you are having labs done by your Primary Care Physician include: CBC, PT/INR, Chem-12 panel, Helicobacter Pylori Antibody, Glucose Fasting, TSH Screen, Magnesium, Phosphorus, B12, Vitamin D: 25 OH - D2 & D3, and Ferritin

☐ **Please have copies sent to us of any recent studies or evaluations you may have had** *(endoscopy report, colonoscopy report with pathology, cardiac stress test, pulmonary function test, sleep apnea study, etc.)*

Nutrition and Psychological Evaluations

Please contact the following professionals to arrange for your psychological evaluations. **Insurance and fees vary among providers, so please call to inquire about fees and to verify they accept your insurance plan before making your appointment.**

Psychologists/Psychiatrists

Ralph Ford III, EdD
909 Gray Road
Traverse City, MI 49686
(231) 946-6235

Michael Hayes, PhD
512 South Union Street
Traverse City, MI 49684
(231) 941-6550

Jennifer J. Sowle, PhD
236 ½ East Front St
Traverse City, MI 49684
(231) 946-6488

Frank W Langer, MSW,PhD
425 N US 31 Ste C
Beulah, MI 49617
(231) 882-5514

Barbara Weber PhD
605 E 7th Ave #9
Sault Ste Marie, MI 49783
(906) 635-7270

Paul Winkler, PsyD, LP.
2240 S Airport Road, #C
Traverse City, MI 49686
(231) 642-4642

Kerrie S. Schroder, PhD
Wayne V. Simmons, PhD
2226 South Airport Rd #A
Traverse City, MI 49684
(231) 947-2442

John Paul Jones, PhD
Steven Reppuhn, PhD
Gaylord, MI 49735
(989) 732-9890
Petoskey
(231) 347-6542 *2 locations

Paul Callaghan, PsyD
Sarah von der Hoff, PsyD
3537 W Front St Suite F
Traverse City, MI 49684
(231) 935-8900

How to schedule your appointment with the Nutritionist:

You will be scheduled to meet with Sandra McSweeney, Registered Dietitian on the same day as your consultation with the surgeon.

Payment for the appointment with the Register Dietician is due at the time of the visit. The cost is $130.00. The Dietician does not bill insurance companies, but will give you a receipt for the visit that you can send to your insurance company or use as an allowed medical deduction on your federal taxes. Cash or checks are accepted, but credit cards are **not.**

Nutritionist

Sandra McSweeney, RD, MPH
701 West Front Street, Suite 200
Traverse City, MI 49684

phone (231) 346-4000 x 219

email: gtsnutrition@hotmail.com

Please bring with you to the appointment:

- ☐ **A three-day food and beverage record -** Indicate the amount of food/beverage consumed in approximate ounces or cups. Meat portions can be estimated by using the size of a deck of playing cards as an estimate of three ounces of meat.
- ☐ **A list of all the medications and any supplements you take**
- ☐ **A time line of your weight changes with a list of weight loss programs you have used**
- ☐ **A list of any questions you have about how your eating will change as a result of the surgery so we can be sure to discuss them.**

General Insurance Information for the Prospective Patient

On their first visit, most of our patients ask: **"Will my insurance pay for the Bariatric surgery?"**

This answer is an individual one that pertains to each individual *insurance company* and *policy.* Every company has an exclusion section that explains the treatments for which the company will or will not pay. **If your policy states that it excludes the surgical treatment of obesity, then it will not pay for the Bariatric surgery, any pre-op tests or clinic visits pertaining to the surgery.** You are responsible to check on your policy before your first visit with us.

Your carrier may ask for specific procedure codes for the surgical treatment of obesity. They are listed below: diagnosis code for **ALL** procedures is **278.01**

- *Roux-en-Y Gastric Bypass surgery procedure code:* ***43644***
- *Vertical Sleeve Gastrectomy surgery procedure code:* ***43775***
- *Biliopancreatic Diversion/Duodenal Switch surgery procedure code:* ***43999***

If it is a covered benefit ask your insurance carrier the following questions:

- What is my deductible?
- What is my co-pay?
- What is my out of pocket maximum?
- What is the criteria that I need to meet?

If an authorization is needed for your first visit to our office, it is your responsibility to get authorization prior to that visit through your primary care physician. Your carrier may ask you for the CPT code, which is either **99205 or 99245** for the consultation visit.

If an authorization is needed and you do not obtain one prior to your appointment, you may be responsible for a consultation fee. We would also like you to remind us if you need an authorization before we schedule any consults with other physicians, tests, or future appointments so that we can promptly take care of the paperwork before your appointment. If you do not remind us to get the authorization, then the scheduled appointment or testing will not be covered by your insurance and you will be responsible for paying the bill.

If you have a commercial insurance that we **do not** participate with you will need to pay the consultation fee. We will courtesy bill for you and then refund you or they will send you a check directly. We will obtain a pre- determination prior to the surgery and if approved you will only pay your deductible and copay.

You will also have a pre-surgical visit *(diagnosis code* ***V7283*** *and procedure code* ***99215****),* which may not be a covered benefit. This will be your responsibility if it is not a covered benefit of your insurance.

On your first visit to our clinic, it is very important that you bring your insurance card with you so that we can make a copy to go into your chart. We refer back to this many times during your care.

****Any changes that occur with your insurance will need to be brought to our attention as soon as possible.**

701 West Front Street, Suite 200
Traverse City, Michigan 49684
Telephone (231)346-4000 / F**ax** (231) 932-7311

ROCHE J. FEATHERSTONE, MD, FACS
MICHAEL A. NIZZI, DO, FACOS
ASHLEY SACHTLEBEN, DO
STEVEN E. SLIKKERS, MD
DAVID M. KAM, MD, FACS
MARY KAY WILLIAMS, MSN, FNP-C

PLEASE PRINT

Patient Name _____
Last First M.I.

Spouse or Parent Name _____

Patient Address _____
Street City State Zip Code

Birthdate _____ Age _____ Marital Status M S W D

Home phone _____ Mobile phone _____

Email _____ Social Security number _____

Employer _____ Phone _____

Emergency Contact _____

Phone _____

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Friend ☐ Other _____

Referring Physician _____ Primary Care _____

Address _____

Phone _____

Ethnicity: Hispanic Non-Hispanic Refused to Report
Race: American Indian Asian Native Hawaiian African American White Other_____
Language: English Spanish Indian Other _____

Health Insurance _____

If spouse name/birth date _____

Policy Number _____

Group Number _____

PATIENT NAME: _____Date: _____

PAST OR PRESENT MEDICAL PROBLEMS

LIST PAST OR PRESENT PROBLEMS SUCH AS CANCER, DIABETES, HEART ATTACKS, STROKES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, ULCERS, SEIZURES, EMPHYSEMA, ETC.

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

ALL PAST OPERATIONS OR SURGERY: (YEAR OF SURGERY)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

SOCIAL HISTORY:

1. Marital status (circle) S M W D

2. Tobacco: _____ never smoked
_____ cigarettes _____ packs per day _____ pipe _____ cigars Stopped
_____ years ago

3. Alcohol – including beer: How much _____ None _____

4. Do you have an advance directive/living will?_____

DRUGS, MEDICATIONS, VITAMIN, OR HERBAL SUPPLEMENTS ☐ Taking No Medications

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

ALLERGIES TO MEDICATIONS: ☐ No known allergies

What happens when you take these medications?

1.
2.
3.
4.
5.

FAMILY HISTORY:

	IF LIVING	**IF DEAD**		**CHECK HERE IF ANY MEMBER HAS HAD**				**OTHER**
	Age	**Age**	**Cause**	**Diabetes**	**HEART TROUBLE *(Heart attack at what age?)***	**HIGH BLOOD PRESSURE**	**CANCER (What kind?)**	
FATHER								
MOTHER								
BROTHERS 1.								
2.								
3.								
SISTERS 1.								
2.								
3.								

ROCHE J. FEATHERSTONE, MD, FACS
DAVID M. KAM, MD, FACS
MICHAEL A. NIZZI, DO, FACOS
STEVEN E. SLIKKERS, MD
ASHLEY SACHTLEBEN, D.O.
MARY KAY WILLIAMS, MSN, FNP-C

E-Prescribing Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescriptions have been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing the Grand Traverse Surgery, PC can request and use your prescription medication history form other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Grand Traverse Surgery, PC, to enroll me in the E-Prescribing Program. I have had the chance to ask question and all of my questions have been answered to my satisfaction.

If you have any questions concerning your account, please call our office for an explanation.

Signed: _____

Print Name: _____

Date: _____

Pharmacy: _____

telephone (231) 346-4000
fax (231) 932-7311
701 West Front Street, Suite 200
Traverse City, MI 49684
www.grandtraversesurgery.com

COMPREHENSIVE SURGICAL CARE

ROCHE J. FEATHERSTONE, MD, FACS
DAVID M. KAM, MD, FACS
MICHAEL A. NIZZI, DO, FACOS
STEVEN E. SLIKKERS, MD
ASHLEY SACHTLEBEN, D.O.
MARY KAY WILLIAMS, MSN, FNP-C

PAYMENT POLICY

Payment for services is due at the time the services are rendered. For your convenience we accept, Cash, Checks, Money Orders, Visa, MasterCard and Discover.

If you have insurance, we will help you receive your maximum allowable benefits; however, deductibles and copays are due prior to services.

Remaining balance can be split equally into **6 monthly payments**. Upon scheduling any procedure you will be informed of an **estimated** balance that you may have.

If you have any questions concerning your account, please call our office for an explanation.

I have read and understand the above payment policy and agree to accept it.

Date: _____

Name: _____

telephone (231) 346-4000
fax (231) 932-7311
701 West Front Street, Suite 200
Traverse City, MI 49684
www.grandtraversesurgery.com

COMPREHENSIVE SURGICAL CARE

Name:_____ Date: _____

Weight Loss History Please check the appropriate boxes and add notes as needed. Please be specific. My obesity started: ☐ in childhood ☐ at puberty ☐ as an adult
☐ after pregnancy ☐ after a traumatic event ☐ _____

Weight Loss Programs/Diets/Medications *(Check all that apply)*
☐ Medifast ☐ Meridia ☐ Redux ☐ Phen-Fen ☐ Optifast ☐ Nutrasystem
☐ Jenny Craig ☐ Slimfast ☐ Diet Center ☐ Metabolife ☐ Atkins Diet ☐ Cambridge
☐ Xenical ☐ Weight Watchers ☐ Medical weight management programs

Weight History: Highest adult weight: _____ Lowest adult weight: _____ Most wt lost on any program: _____

Taste preferences *(Check all that apply)* ☐ Sweets ☐ Salty ☐ Fast food ☐ Comfort foods ☐ _____

Eating Habits *(Check all that apply)* ☐ Binge eater ☐ Stress ☐ Boredom ☐ Loneliness ☐ _____

Family History: Please check which, if any, of your family members had any of the following conditions:

Condition	Sibling	Mother	Father	Grand parent	Aunt/ Uncle	Comment:
Anemia						
Bleeding Problems						
Blood Clots						
Cancer						
Diabetes						
Gallstones						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Obesity						
Sleep Apnea						
Stroke						

Obesity Related Conditions *(Check if you have any of the following conditions)*

☐ Belching of sour fluid
☐ Coughing or choking at night
☐ Daytime falling asleep
☐ Diabetes mellitus
☐ Gout
☐ Heartburn/esophagitis
☐ High cholesterol
☐ Joint pain/Arthritis
☐ Shortness of breath
☐ Sleep apnea syndrome
☐ Bulimia/Excessive vomiting
☐ Daily headaches
☐ Depression
☐ Gallbladder disease
☐ Hernia
☐ Hiatus hernia
☐ High blood pressure
☐ Leakage of urine
☐ Rash/Dermatitis
☐ Swollen ankles/feet

Patient Essay: Please describe, in your own words, how living with clinically severe obesity affects your daily living. Further, please express why you would like to have Bariatric surgery and what you expect your life to be like after Bariatric surgery *(You may use additional paper if necessary)*.

Patient review questionnaire (Quiz)

Name: _____ Date: _____

Please read each question carefully, and then write T (true) or F (false) on the line next to the statement.

1. _____ Besides the different types of obesity surgery, there are other forms of weight loss programs such as prescription medications, diet and exercise and medically supervised diets that can help a person lose weight.

2. _____ Diabetes, high blood pressure, back pain and similar ailments are guaranteed to get better after obesity surgery.

3. _____ Staple or suture lines may leak, resulting in infection involving the stomach or the skin.

4. _____ Behavior modification is an important part of obesity surgery and will enhance the success of weight loss.

5. _____ Re-operation is sometimes necessary due to bleeding, ulceration, bursting of stitches or staples, leakage, blockage of the intestines or other causes.

6. _____ Obesity surgery will commit me to periodic physician follow-up visits for the rest of my life.

7. _____ Weight loss is guaranteed after obesity surgery.

8. _____ After gastric bypass, sugars can cause dumping syndrome. Symptoms may include bloating, cramps, lightheadedness, sweating and fast heart rate. It is recommended after this type of surgery to avoid sodas, candy, sweet fruit, milk shakes and sweetened cereals.

9. _____ After obesity surgery, the patient is committed to taking vitamins and undergoing nutritional assessments/studies for life.

10. ____ After obesity surgery, you will be required to take B12 sublingual (under the tongue) for the rest of your life to prevent long term anemia.

11. ____ Regular exercise is not recommended after obesity surgery and does not affect one's weight loss outcome.

12. ____ To be successful with obesity surgery, one must make lifestyle changes, such as establishing an exercise routine and choosing appropriate nutritional foods and liquids daily.

13. ____ Monthly group support meeting are a crucial part to the success of obesity surgery.

14. ____ Patients never feel nauseated or vomit after obesity surgery.

15. ____ Anti inflammatory medications such as Aleve, Bayer, Aspirin, Ibuprofen, Motrin and Naprosyn can cause stomach ulcers with gastric bypass. It is important to avoid these medications for life.

16. ____ Changes in bowel habits may occur and could include diarrhea, constipation, gas and/or foul smelling stool.

17. ____ One cannot gain the weight back after obesity surgery.

18. ____ Obesity surgery is an easy operation and not a very risky one.

19. ____ Complications are always infrequent and minor after obesity surgery, so it is important not to bother the doctor after hours.

20. ____ In order to have obesity surgery, one must be a non-smoker for 8 weeks prior to surgery and be committed to avoiding alcohol for at least one year after surgery.

EDUCATION SEMINAR ACKNOWLEDGEMENT:

I _____, acknowledge to have attended the education seminar on bariatric surgery. I have received detailed explanations on:

1. My role with bariatric surgery
2. Setting realistic expectations
3. Types of bariatric surgeries
4. Benefits and risks of bariatric surgery
5. Expected weight loss
6. Overview of the diet after gastric bypass.

I have been given a syllabus to help me follow the lecture. The syllabus is mine to keep. I am aware that the surgeon and staff are available to me by phone or e-mail to answer questions I may have at any time. I will be able to discuss my specific medical concerns with the nurse and surgeon during my consultation appointment.

Patient Signature: _____ Date: _____