Bariatric Pre-Surgical Psychological Evaluation

Cheryl Millsaps, Ph.D.  Birmingham Neuropsychology, LLC  Richard L. Azrin, Ph.D.

4260 Cahaba Heights Court, Suite 180, Vestavia, AL 35243

Phone (205) 329-7815  Fax (205) 329-7816  www.brookwoodclinic.com  Jamie.BhamNeuro@gmail.com

Doctor / Other ____________________ has referred patient: ____________________ for an evaluation

On Appointment Date: ____________________ Time: ________________

Please fill out the Bariatric Pre-Surgical Evaluation Form before the appointment and bring that form to the appointment, along with your glasses (if needed) for reading and a sweater because the building may be cold. Psychological assessments are commonly requested for individuals who are about to undergo bariatric surgery. Your assessment will be conducted by Dr. Cheryl Millsaps or Dr. Richard L. Azrin, Licensed Psychologists and does not involve a medical check-up. The evaluation usually lasts from 3 to 5 hours. A good night’s sleep and breakfast are recommended. If you have difficulty reading or writing, please inform our office prior to the appointment so that accommodations may be made.

If you have any questions, please call (205) 329 7815

Directions:

From Downtown or Hwy 31 - Take Hwy 280 going South. You will pass Whole Foods on your left. Be in the Right lane. Take ramp to Cahaba Heights on the Right. At the end of the ramp turn Left onto Pump House Rd. Pump House Rd turns into Cahaba Heights Road. You will pass Starbucks on your Left. Immediately after Cahaba Heights Methodist Church, Turn Right onto Cahaba Heights Court (Cahaba Court sign), just before the Slappey Communications Sign.

From Hwy 459 at Hwy 280 - Turn into the Summit shopping Center on Summit Blvd. Pass the shopping areas on both sides. Turn Left on Cahaba Heights Road; you will see two veterinarians at that intersection. You will then pass Cahaba Cycles on your Left. Turn Left on Cahaba Heights Court (Cahaba Court sign) just past the Slappey sign. If you see Starbucks on your right you have gone too far.

PARKING - The closest parking is all the way in the back of the 4260 Building (South Parking Lot): Follow the arrows to our South Parking lot on the map you see here. After you turn onto Cahaba Heights Court (Cahaba Court sign), go straight until you see the Slappey Communications Building at 4260.

We are on the opposite side of the entire building in the South Parking lot. Circle around the LEFT side of the entire building by following the RED Doctors Offices signs to the South Parking Lot in the back of the entire building, or park in front of Higher Ground Coffee and walk to the right of Higher Ground Coffee to the back lot.
Instructions: Please complete this form as accurately/completely as you can. A doctor will discuss your responses with you during your appointment.

Patient’s Name: Mr. /Ms. /Mrs. _____________________________ Evaluation Date: __/__/____

Best Phone #: _________________ Work/Other Phone #: _________________

Date of Birth: ____/____/____    Age: _______    Race: ___________ Gender: _________________

Marital Status (circle) Single / Married / Partnered / Divorced / Separated / Widow

Which surgeon (or doctor) referred you to this clinic? Dr. ________________________________

Which surgery are you interested in having? (circle) Gastric Bypass/ Gastric Sleeve / other: __________

Approximate surgery date? ________________________________

Weight Loss History / Surgery Knowledge (Office Use Only) I__ O___ L__ G:_____

What is your approximate current weight? ______ Height? _____ Goal Weight after surgery? ______

What are your reasons for wanting the surgery? ____________________________________________

Have you attended any Surgical Seminars or support groups? (circle) Yes No

Do you feel you understand the surgical procedure? (circle) Yes No

If No, Questions: _________________________________________________________________

Do you feel you understand the lifestyle changes required after surgery? (circle) Yes No

If No, Questions: _________________________________________________________________

Do you feel your family / friends/ employer are supportive about you having surgery? Yes No

If not, please describe any difficulties __________________________________________________

Have you ever taken laxatives or vomited on purpose because you ate too much food? Yes No

How much and how often do you exercise? _____________________________________________

Exercise limitations (describe): _______________________________________________________

Are any of the following usually in your diet? (circle all that apply)

Soda  Sweet tea  Juice  Fried Foods  Sugar

Bread  Pasta  Rice  Coffee  Alcohol
Please list a few types of diets you have tried in the past: ___________________________________
_________________________________________________________________________________

Are you following any type of diet now?  No/ Yes
Please describe__________________________________________________________________________

Medical History (circle all that apply)
Short of Breath  High Blood Pressure  High Cholesterol  Sleep Apnea  Arthritis
Diabetes  Stroke  Cancer  Head Injury  COPD  Asthma  Incontinence  PCOS
Thyroid disorder  Heart Disease  Acid Reflux/ GERD  Other ____________________________

Pain in:  Back  Hips  Knees  Feet  Other ____________  Swelling (where) ____________

Past Surgeries:  Back  Knee  Gallbladder  Bariatric  Other: ____________________________
_________________________________________________________________________________

Significant Symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Circle Yes or No</th>
<th>When it began</th>
<th>Please briefly describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory Difficulties</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Energy</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Motivation</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Happiness</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Isolation</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistently Depressed Mood</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry Outbursts</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive Worry</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinations</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy/ counseling</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric medication</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other symptoms</td>
<td>No Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current Medications (or attach list):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>What is it for?</th>
<th>Name of Medicine</th>
<th>What is it for?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 1/20/2020
Family History (circle all that apply for your parents, siblings or children)
Diabetes  High Blood Pressure   Heart Disease  Obesity  Stroke  Cancer
Alcoholism  Drug abuse  Alzheimer’s Disease  Other types of Dementia

Family history of Psychiatric Illness (Circle) Major Depression  Anxiety Disorders  Schizophrenia
other(list) __________________________

Substance Use
Do you currently drink any alcohol?   No    Yes
Average amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc) ________________
Have you ever been addicted to any drugs?   No    Yes  (describe) ________________________________
Have you been involved in any treatment for alcohol (including A.A.) or using drugs?   No    Yes
(describe)______________________________________________________________
Have you ever felt like you needed help to stop using alcohol or drugs? _________________________

Tobacco use
Do you currently smoke cigarettes?   No    Yes
If you smoked previously, when did you stop? ________________________________________________
Approximately how many years smoked in lifetime: _______Average number of packs/day: _____
Do you currently (circle all that apply) Vape  Chew Tobacco  Dip Tobacco

Educational/Occupational History:
Education:  High school degree?   Yes    No    Years of college _______ Trade school _______
Occupation: ___________________________________________________________ Currently working?   No    Yes

Social History
Spouse or Partner Living with you? (# years _____)
How many kids do you have? _______ Are they living in your home? #_______
Parents or others living with you: ________________________________________________
Do you have someone who can take care of you after you are released from the hospital? No    Yes
Name: __________________________ Relation: __________________________
New Patient Information

Patient Name (Last)____________________________ (First)____________________________ (M.I.)______

Address_______________________________________City__________________State_______Zip________

Sex: M   F    Patient’s Employer_______________________________________________________

Birth Date __________________ Age________ Social Security Number _____________________________

Home Phone (       ) Work (       ) Cell (___)_________________

Marital Status: __________ Driver License #: ___________

Email (Test results may be sent to this address): ________________________________________

Spouse/Partner Name __________________  Spouse Soc Sec #:_______________

Spouse place of Employment ________________________________  Spouse Phone #: _____________

Other Emergency Contact _________________________ Relationship to Patient _____________________

Emergency Contact Phone (____)________________

Insurance Information

1) Name of Primary Insurance:

   Contract #________________________ Group #___________________ Effective Date_____________

   Policy Holder’s Name: ___________________ DOB_________ Soc Sec Number ____________
   Relationship___________ Employer_______________ Phone #’s: __________________________

2) Name of Secondary Insurance:

   Contract #________________________ Group #___________________ Effective Date_____________

   Policy Holder’s Name: ___________________ DOB_________ Soc Sec Number ____________
   Relationship___________ Employer_______________ Phone #’s: __________________________

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address______________________________________________ ____________________________________

Alternate Telephone_______________________________ Alternate Telephone_______________________________

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 4260 Cahaba Heights Court, Suites 180-182, Vestavia, AL 35243 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have seen or received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been shown or given a copy of the HIPAA Notice Form.

COMMUNICATION REGARDING MY ACCOUNTS: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) Voicemail messages, and other forms of communication.

Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

Signature of Patient or Responsible Party: ___________________________ Date ________________

If signed by a responsible party, describe that representative’s authority to act for the patient_____________________________ _
Patient Name: __________________________  Date of Birth: ___________________ 

Social Sec. #__________________________ Date(s) of requested records: ___________________

I hereby authorize the above providers to obtain and release the protected information specified below. Please list any restrictions on this release of information

Name____________________________ Phone_________________ Fax______________________
Address_____________________________________________________________________
City                     State                   Zip
Name____________________________ Phone_________________ Fax______________________
Address_____________________________________________________________________
City                     State                   Zip
Name____________________________ Phone_________________ Fax______________________
Address_____________________________________________________________________
City                     State                   Zip
Name____________________________ Phone_________________ Fax______________________
Address_____________________________________________________________________
City                     State                   Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctor’s last progress notes.

Release: This form when completed and signed by you authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Leslie Kahn, LCSW, Dr. Frank Brotherton, Dr. Kristi Yarbrough, Dr. Christopher Litton and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals. I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist, psychiatrist, or social worker generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

_________________________________ _____________________________ _________________
Name of patient and/or responsible party Signature of patient or responsible party  Date

If signed by patient’s representative, a description of representative's authority to act for the patient is provided above.

*** Please fax records to Fax# (205) 329-7816 OR call Voice # (205) 329-7815