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

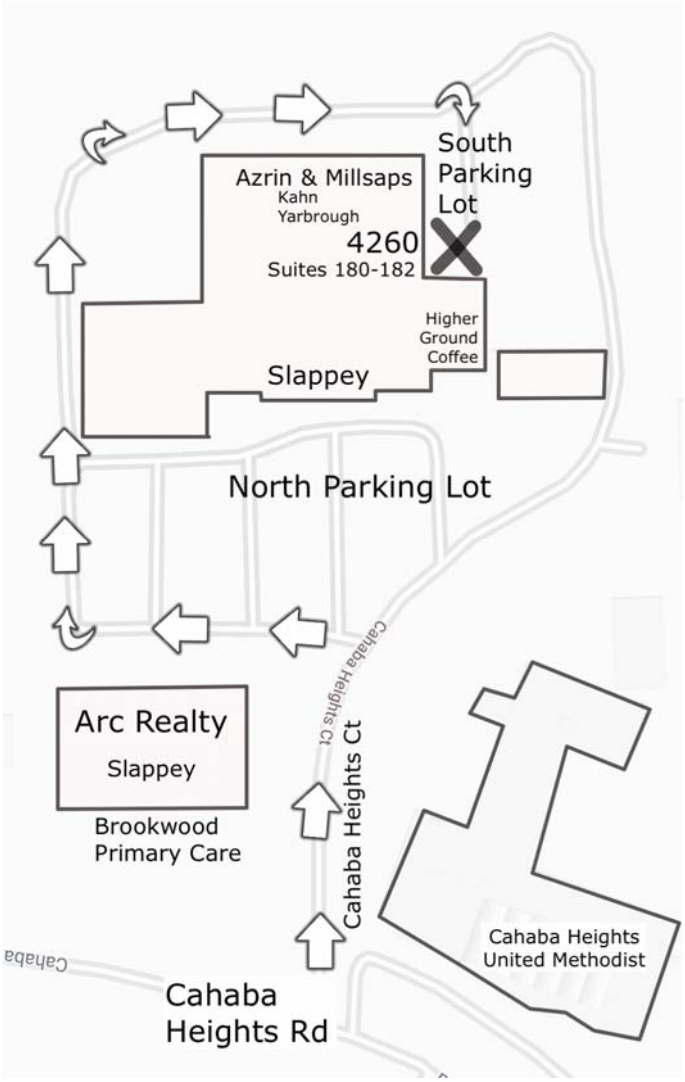
Directions:

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.



Bariatric Pre-Surgical Evaluation Form
CONFIDENTIAL

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

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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:

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

Current Medications (or attach list):

Name of Medicine	What is it for?	Name of Medicine	What is it for?

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_____

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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

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**

Revised 1/20/2020