CAPE FEAR VALLEY HEALTH

Bariatric Weight Loss Program

4 MONTH PHYSICIAN SUPERVISED DIET

Your insurance company requires you follow a medically supervised diet and exercise program for 4 months in order to be approved for weight loss surgery. This means your primary care provider has given you a dietary recommendation to follow. You will be required to see your provider on a monthly basis for him/her to document your progress, along with any type of exercise you are doing and to be weighed in. This program can only be supervised by an MD, PA or FNP. We have included forms for your doctor to complete at each visit with as much detailed information as possible. These forms are accepted by your insurance and will ensure compliance. If you or your doctor has any questions regarding this program, please contact the Bariatric Coordinator at the following:

Dr. Classen
910-829-6581

Dr. Ejeh / Dr. Appresai
910-615-2776

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Documentation for 4 Month Physicians Supervised Diet/Exercise Program Progress Note

Today's Date ____ / ____ / ____ Patient's Name ______________________________

DOB ____ / ____ / ____

Reason for visit: ____Weight Loss____________________________________

*Weight ______________ *Height ______________ *B/P ______ / ______ *P ______ *R ______

HPI: ____

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***Diet History:** List any/all diets patient is currently participating in (to be reviewed at each visit). Please document dietary changes, caloric changes, nutritional assessments, behavioral modifications, medications discussed with patient or patient is currently implementing.

***Exercise:** List exercise habits or changes in exercise habits patient has implemented. Please document discussions and recommendations for exercise.

***Plan:** Document assessment of patient's progress during 6-month program and discussed plan for weight loss success. Document goals discussed and expected outcomes by next month's visit.

Physician's Signature ____

[1]* All the above documentation must be as detailed as possible. This form is intended solely for documentation of weight management, no other health problems should be reviewed on the document. The patient must be followed monthly for 4 months. If the patient misses/skips a visit, they will be required to begin documentation from the start.

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Letter of Referral for Weight Loss Surgery

Patient Name ____ DOB ______________________

The patient named above is a patient of mine with a longstanding history of obesity that has been refractory to medical weight loss regiments. The patient's obesity related comorbidities include:

____

____

____

____

____

The patient's additional medical history is significant for:

____

____

____

The patient's most recently recorded height and weight:

Height: _____________ Weight: _____________ BMI: _____________ Date: _____________

My patient is motivated to make lifestyle changes required to maximize the likelihood of successful, sustained weight loss and would therefore benefit from consideration for weight loss surgery in order to improve their overall health, quality of life, and to minimize their risk of obesity related comorbidities.

Please evaluate my patient as a candidate for weight loss surgery. If considered an appropriate candidate:

___ The patient is medically cleared for surgery

___ I will need to see the patient back in the office for formal pre-operative clearance

Physician's Signature ____ Date ______________________

I have also enclosed documentation of prior weight loss efforts and the patient's weights at our office.