

Bariatric “Continuation of Care” Surgery

Patient Full Legal Name: (first, middle, last name)		Mr. ___ Miss. ___ Mrs. ___ Ms. ___	Marital status(circle one) married / single / divorced / widow	
Social Security Number: _____-_____-_____	Maiden Name:	Primary Phone:	Alternate Phone:	
Street address:		City:	State:	Zip:
Date of Birth: ___/___/___	Age:	Height: ft ___ in ___	Weight:	

- I have attached a copy of the front and back of my insurance card(s). **And**
- I called my insurance and I do have bariatric “weight loss” surgery.
- I called my insurance and I **DO NOT** have bariatric “weight loss” surgery benefits, I will be self-pay.

Put a check next to the weight loss surgery you had:

- Lap. Roux-n-Y Gastric Bypass Open Roux-n-Y Gastric Bypass Duodenal Switch
- Lap. Sleeve Gastrectomy Lap. Gastric Band, I had “Lap Band” or “Realize Band” (circle one)
- Other: _____

I am requesting Continuation of Care post “weight loss”:

- Program where I had surgery closed
- My insurance has changed and original program does not take my insurance
- I am relocating to the St. Louis area from _____
- Other: _____

The following documentation and testing are needed prior review:

- Operative note from your original weight loss surgery
- Original Surgeon’s office note (if available)
- Operative note from any complications or revisions after surgery (if applicable)
- Follow up office visit(s) after surgery with MD/NP/Dietician

What was your weight prior to surgery _____ and what was the lowest weight after surgery _____?

Compile requested documents listed above and mail to our office in one large envelope

- Use this check list as your cover page.
- We are not accepting revision requests via fax.
- Requests received that are missing requested documents are at risk of being delayed.
- Please allow 30 to 45 business days for review.

Thank you,
 Washington University Bariatric Surgery
 Please call our office if you have any questions.
 314-454-7224 option 1

Mail to:
MIS Surgery – Bariatric Surgery
Revision Bariatric Surgery
660 South Euclid
Campus Box 8109
St. Louis, MO 63110

Thank you for choosing The Washington University’s Surgical Weight Loss Program!

www.weightlossurgery.wustl.edu

Are you seeking revision of previous weight loss surgery? NO YES

If YES, what was your original surgery _____ when was it performed _____

Height: _____ feet _____ inch Weight: _____ pounds BMI: (office use only _____)

Check all that apply to you: Diabetes Heart Disease Sleep Apnea High Blood Pressure

Other _____

(Please note a diagnosed co-morbid condition may be required by insurance and/or our program.)

Print Full Legal Name: _____ **Date of Birth:** ____/____/____

Gender at birth: Male Female Gender you identify with: Male Female

SSN: _____ Maiden Name: _____ Preferred Language: _____

Cell #: _____ Work #: _____ Land line #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____@_____

Emergency Contact: (first/last) _____

Phone: _____ Relation: _____

Primary Physician: (first/last) _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I do not have a Primary Care Physician.

Referring Physician: (first & last) _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I do not have a "Referring Physician", I am "Self" referring.

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Primary Insurance Name: _____ Phone: _____

PO Box: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Policy Holder's Employer: BJC Wash.U. Other: _____

Policy Holder Relation: Spouse, Parent, Self (if "Self" skip to "Secondary Insurance")

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address if different from patient: _____

If Tri-care insurance - Branch & Member ID SSN: _____

Call insurance. Is weight loss surgery covered? **Yes** **No** **I will be self pay.**

Secondary Insurance Name: _____ Phone: _____

PO Box: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Policy Holder's Employer: BJC Wash.U. Other: _____

Policy Holder Relation: Spouse, Parent, Self (if "Self" skip to "Secondary Insurance")

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address if different from patient: _____

If Tri-care insurance - Branch & Member ID SSN: _____

Call insurance. Is weight loss surgery covered? **Yes** **No** **I will be self pay.**

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Washington University in St. Louis

SCHOOL OF MEDICINE

Division of Minimally Invasive & Bariatric Surgery

Dear Patient:

Thank you for choosing the Washington University Bariatric “Weight Loss” Surgery program. We take our partnership with you very serious and look forward to providing you with exceptional services, enabling you to achieve the best possible outcomes from your weight loss surgery journey. To achieve this, we ask that you:

- Arrive 15 minutes early with completed paperwork for each scheduled appointment as a sign of consideration to yourself, other patients and your faculty practitioner. Depending on complexity of appointment you can expect appointments to last at least 60 minutes.
- Patients arriving late or without completed paperwork for appointment will be asked to reschedule.
- Contact 314-454-7224 option 1 if you are unable to keep your appointment. At least 48 hour notice is expected for cancelled appointment.

Though we understand that sometimes life gets in the way of scheduled appointments. Please understand that we cannot provide the level of service to you or other patients if you fail to keep appointments made for you. If you cancel, reschedule, or no show for 3 appointments we will discontinue our partnership.

We are very pleased that you have selected Washington University Bariatric “Weight Loss” Surgery, and thank you in advance for your full participation in the goal of achieving optimal outcomes from our work together.

Signature of patient or authorized person	Date	Patient’s relations to person authorized to consent

Signature of Guarantor if applicable	Date	Patient’s relations to Guarantor

Washington University Bariatric “Weight Loss” Surgery
 Campus Box 8109
 425 S. Euclid, Ave
 St. Louis, MO 63110
 Phone: (314) 454-7224 option 1
 Fax: (877) 991-4780
 Website: wls.wustl.edu

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