

## Patient Contract

This Patient Contract is supported by my surgeon, Dr. \_\_\_\_\_, and will be effective and ongoing from the date of my initial evaluation for **Vertical Banded Gastroplasty (VBG)**. The purpose of this Contract is to outline and document that I, \_\_\_\_\_ (patient name) understand and agree to follow all of my surgeon's instructions, protocols and directions before and after my surgery.

Bariatric surgery is a special opportunity for patients with obesity to improve the quality of their lives. My surgeon's weight loss program is dedicated to promoting and providing the option of bariatric surgery to all qualified candidates. However, **it has been well documented that bariatric surgery patients who are not compliant with medication, postoperative instructions, and outpatient follow up visits, or who otherwise do not take care of themselves, have a higher degree of complications.**

I affirm that I am significantly overweight and have attempted non-surgical weight loss programs without success. My surgeon has explained that obesity can cause early death and significant medical problems including, but not limited to, hypertension, diabetes, obstructive sleep apnea and high cholesterol.

**I understand that medicine is an unpredictable field. Unpredictable complications can occur. No amount of pre-operative testing can assure an uncomplicated outcome. I have the responsibility to inform my surgeon of any concerns, worries or possible complications at the earliest possible time. I agree that my surgeon may make recommendations, and I take full responsibility if I do not follow these recommendations.**

I understand that significant weight loss is a life-altering event. Significant changes in eating behavior occur. I understand that every patient's experience varies and the exact extent of my ability to cope with significant forced behavior changes cannot be predicted. I understand that my surgeon can assist in locating a mental health provider who can help me with behavioral needs.

**Medication problems:** I understand that I will have to monitor my post-operative medication doses closely with the physicians that have prescribed them. My surgeon and physicians will help if necessary. Examples of common medication problems include lightheadedness from too high a dose of high blood pressure medication and too low a blood sugar level from excessive diabetic medication. I agree to work closely with my primary care physician to regulate my medication.

**Depression:** I understand that it is my responsibility to seek psychological help, if needed. Although most people experience improvements in their mood, some will have worsening states of depression. Weight loss is not a cure-all for all psychological problems. It is my responsibility to seek psychological help when necessary.

**Smoking and other addictions:** If I currently smoke, I agree to and take full responsibility to quit smoking to prevent potential life threatening illnesses. Addiction to alcohol, narcotics and other illicit drugs will severely impact my health.

**Return to work:** I understand that although many patients can return to work within one to two weeks, some patients may require a longer recovery. My surgeon and physicians are not responsible for any financial difficulties due to lost work time.

## Patient Contract

**Poor weight loss and weight regain:** Poor weight loss or weight regain may occur. The consumption of soft, high calorie foods such as ice cream and high calorie beverages will not be inhibited by the band. Careful food choices will be necessary in order to achieve weight loss. I will take responsibility for my eating behaviors.

Exercise is an excellent means to improve health and maintain weight loss. I take responsibility to increase my physical activity and will discuss with my surgeon and physicians healthy ways to do so.

My doctors will give me recommendations in how to experience the most optimal weight loss. There is no guarantee that I will achieve my goal weight. I understand that the chances of reaching my ideal body weight are low. I understand that it is my responsibility to maintain healthy eating and exercise habits as prescribed by my surgeon and physicians to assist in maintenance of optimum weight loss.

**Food intolerances:** I understand that if I do not change my eating habits, food may get stuck and cause discomfort and/or vomiting. Prolonged vomiting can cause complications. I take responsibility to follow my surgeon's dietary recommendation.

**Pregnancy:** Women who were infertile may become fertile after their VBG surgery. If I am a female, I understand that I will need to use birth control to prevent unexpected pregnancies for 24 months after this procedure. The risks associated with pregnancy in an obese person are generally higher than those in a non-obese person. There is no significant data to suggest that the risks of pregnancy are greater, either to the mother or child, after gastric banding surgery. However, the safety of pregnancy is NOT established for patients or their fetus during periods of rapid weight loss. **For this reason I agree not to become pregnant for 24 months after my VBG surgery. I understand that serious, life-threatening complications may occur. I take full responsibility for using reliable birth control during this period of time.**

If I intend to become pregnant, I agree that before and during pregnancy, I will discuss my nutritional needs with my surgeon and obstetrician. I will always make sure that I am taking adequate vitamins and minerals throughout pregnancy and while nursing. I understand that my surgeon is not responsible for complications of pregnancy as complications may occur with any pregnancy, and there is no definitive means to prove any complication during pregnancy was due solely to the gastric banding surgery.

I understand that I may not be able to breast-feed during periods of rapid weight loss. If I am currently breast-feeding, I plan to wean my child before undergoing weight loss surgery.

*I plan on following all post-operative visits recommended by my surgeon and his staff. I plan on obtaining all tests requested by my surgeon and associated staff. I agree to attend routine clinical follow up visits with the physician, and/or his associated staff to include:*

- *2 weeks post-operatively*
- *I will come for routine 3, 6, 9, 12, 18, 24 month visits with the dietitian to evaluate my eating habits and progress*
- *I will meet with my surgeon as directed by him or his staff*
- *I agree to have a nutritional lab panel at 6 months, 12 months, and yearly thereafter*

*I will abide by all nutritional supplements/recommendations that my surgeon and staff prescribe. If my surgeon's practice ever ceases to exist, I take responsibility to find an appropriate physician to monitor my life-long follow-up. If I leave the area I take responsibility for finding appropriate follow-up care. I understand that proper medical follow-up requires a financial commitment that may include*

**Patient Contract**

*maintenance of health care insurance. There may be costs in the form of fees, co-payments, deductibles, lost time from work and transportation. These may not always be covered by my insurance company and I will take financial liability. These costs may be greater than planned in the event of complications.*

\_\_\_\_\_(**Initial Here**) *I authorize my surgeon's office to communicate with my primary or specialty physician to obtain information related to my surgery such as: change of address of telephone number, weight and vitals, the status of my comorbidities, and lab tests.*

This Patient Contract has been thoroughly reviewed and explained to me, and my signature reflects my understanding of its purpose and expectations, as well as my agreement to its terms.

By signing this Patient Contract, I agree to follow the guidelines and instructions set forth above, and understand that my failure to comply may impact the result of my surgery.

_____ Patient Signature	_____ Date
_____ Surgeon Signature	_____ Date
_____ Witness Signature	_____ Date