BARIATRIC SURGERY SUPPLEMENTAL APPLICATION

Please provide additional remarks and/or explanation on page 2.

SURGEON		
NAME:		
Types and numbers of Procedures performed:	**Open**	**Laparoscopic**
1. Roux-en-Y		
2. Laparoscopic Adjustable Gastric Banding		
3. Vertical Banded Gastroplasty		
4. Biliopancreatic Diversion		
5. Other bariatric procedures		
	Where ?	**How long?**
6. Completed Accredited Bariatric Surgery Residency or Fellowship		
7. Completed advanced laparoscopic fellowship including lap bariatric procedures		
	Yes	**NO**
8. Documentation of 20 proctored Bariatric surgeries. Provide documentation of proctored cases.		
9. Performed a minimum of 100 documented Bariatric surgeries. Provide documentation of outcomes.		
10. Primary bariatric surgeon for a minimum of 50 cases annually. Provide documentation of outcomes.		
11. Board Certified General Surgeon by ACS.		
12. Meets privileging guidelines of the American Society for Metabolic and Bariatric Surgery.		

PROGRAM		
Patient Selection Criteria	**Yes**	**NO**
1. BMI Standards:		
* >35 with comorbidities		
* >40 for weight loss		
2. 100 pounds over normal body weight		
3. Pediatric/Adolescent Patients (under 18 years old)?		
4. Patients over 65 years old?		
5. **Extensive Pre-Op Evaluation Program** – send copy of program.		
* Co-morbidities; extensive lab work		
* Psychology/psychiatry testing, evaluation and consults		
* Pulmonary/cardiology consults		
* Dietitian/nutritionist consults		
* Substance abuse screening		
* Assess patient pre-op compliance. Provide document.		
* Formal Staff Education Program		
* Anesthesia Consultation		
6. **Extensive Patient Education Program** – send copy of program.		
* Videos/reading material/quizzes		
* Health, not cosmetic		
* Diet/nutrition education		
* Support group		
* Family participation		
* Extensive informed consent		
* Weight loss, exercises, pre-op		

7 . **Extensive Follow-Up/Post-Op Evaluation Program**		
* Percentage of patients followed at 1 week		
* Percentage of patients followed at 3 months		
* Percentage of patients followed at 6 months		
* Percentage of patients followed at 1 year		
* Percentage of patients followed annually for life		

FACILITY			
Facilities where procedures are performed: **Name**	**ASMBS/SCI Accreditation**	**City/State**	
		Yes	**NO**
1. Does each facility have all equipment necessary to accommodate this class of patient?			
2. Does each facility have imaging equipment in facility designed for morbidly obese patients?			
3. Is each facility equipped with furniture, Imaging devices, OR equipment and emergency supplies suitable for morbidly obese patients.			
4. Does each facility have specialists available in facility, to include pulmonology, interventional radiology and cardiology to treat unexpected complications?			
5. Is each facility fully equipped to handle morbidly obese Critical Care patients including, ICU and MD Anesthesia?			
6. Does each facility have Nursing Staff specially trained to treat this class of patient?			
7. Is each facility certified by ASMBS/SCI?			
8. Is an ASMBS/SCI accreditation request pending?			

Additional Remarks/Explanation (please refer to section and question):

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Please include a summary of your Professional Liability Claim History using the Supplemental Claim Information form attached (please duplicate if needed)

I hereby declare that the information provided in this Questionnaire is true and complete to the best of my belief, knowledge and recollection and that I have not willfully concealed or misrepresented any material facts or circumstances.

Signature: ______________________________ **Date:** ______________

Name (please print): ______________________________