NORTON WEIGHT MANAGEMENT

Dr. Jeff Allen
Dr. Ben Tanner
Dr. Meredith Sweeney

Thank you for your interest in transferring your care to Norton Weight Management. Please complete the following to start our transfer process.

- Complete the following packet entirely
- Obtain your original weight loss surgery operative note
- Obtain any additional operative notes pertaining to your weight loss surgery
- Laparoscopic gastric band patients will also need to obtain the surgical implant record
    - PLEASE NOTE if you have a laparoscopic gastric band and are interested in converting to a Roux-en-Y Gastric Bypass DO NOT complete this packet. Please call, 502-629-1234, choose option 4 to register to attend one of our surgical seminars. You can also register on our website.
- Obtain any recent imaging/diagnostic test of your abdomen, chest, pelvis
- Obtain any recent Endoscopy (EGD) operative notes and pathology
- Provide a copy of your insurance card

Please submit the completed packet with your records to our office for our surgeons to review.
Fax: 502-899-6407
Email: Weightmanagement@nortonhealthcare.org
Address: 1000 Dupont Rd. Louisville, Ky. 40207

Our surgeons review all transfer request to determine if they are able to accept transfer of care. The office will contact you if any additional information is needed. If accepted, a new patient appointment will be scheduled for you at that time. If you are accepted and seeking a revision, we cannot guarantee that our surgeons will be able to offer you one. Revision surgeries are dependent upon certain criteria and testing. If you are offered a revision, you will then have to complete our surgical assessment process, including a $300 non-refundable fee, and any insurance requirements you may have. We ask that you contact your insurance company directly, prior to your appointment, to inquire about your Bariatric coverage and any surgery requirements you may have.

You must be at least 90 days out from your original or any revision weight loss surgeries before applying for transfer of care.
Our surgeons do not accept any current smokers or nicotine dependent (e-cigarettes) patient transfer request. You must be at least 6 months nicotine free before you may apply for transfer of care.
If you have any questions please contact our office at 502-899-6405.
Thank you again for choosing Norton Weight Management

Transfer of Care

Patient Information Packet

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____
Date of Birth: _____ Height: _____ Weight: _____ BMI: _____

Address Information:

Street Address: _____
City: _____ State: _____ Zip Code: _____
Best phone number to reach you: _____
Okay to leave a message on this number: Yes _____ No _____

Previous Weight Loss Surgery Information:

Original weight loss surgery? _____
Original weight loss surgeon? _____
Date of Surgery: _____
List any complications requiring hospitalization: _____
_____
Have you already had revision surgery? Yes ____ No ____
If yes, what revision was performed and who was your surgeon?
_____
Reason for transfer of care? _____
Are you currently having problems related to your weight loss surgery? Yes ____ No ____
If yes, please explain? _____

Surgical History:

None: ___
Gallbladder: ___ Open ___ Laparoscopic
Appendectomy: ___ Open ___ Laparoscopic
Hernia: ___Hiatal ___ Abdominal
Endoscopy: ___ Yes ___ No
Nissen Fundoplication ___ Yes ___ No
Heart Surgery: ___ Yes ___ No
If yes, what type? _____
Other abdominal surgeries: _____
Other: _____
Other: _____

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia:

___ NONE
___ Nausea ___ Vomiting ___Heart Stopped ___ Stopped Breathing
___ Woke up during procedure _____Other

Social History:

Do you smoke? ___ YES ___ NO
Have you smoked in the past? ___ YES ___ NO
If yes, when did you stop smoking? _____
Do you use smokeless tobacco? ___ YES ___ NO
Have you used smokeless tobacco in the past? ___ YES ___ NO
If yes, when did you stop using smokeless tobacco? _____
Do you use snuff or chew? ___ YES ___ NO
Do you use street drugs? ___ YES ___ NO
If yes, what drugs? _____

Medical History/Review of Symptoms: (Check all that apply)

Cardiovascular:
High blood pressure ___ Deep Vein Thrombosis (DVT) ___
Blood Clot in lungs (pulmonary embolism) ___
Heart disease/Prior heart attack ___ Pacemaker/Defibrillator ___
Congestive heart failure ___ Atrial Fibrillation / Arrhythmia ___
Heart murmur ___ Prior stroke or TIA ___
Other _____
NONE ___

Endocrine:
Diabetes ___ Elevated Cholesterol / Triglycerides ___
Under / Overactive thyroid ___ Pre-diabetes ___
Endocrine gland tumor ___
Other _____
NONE ___

Respiratory:
Asthma ___ Obstructive Sleep Apnea ___
COPD / Emphysema ___ CPAP or BPAP ___
Other _____
NONE ___

Bladder / Kidney:
Kidney Failure / Renal Insufficiency ___

Other_____
NONE ___

Gastrointestinal:

GERD / Heartburn ___ Barrett's esophagus ___
Achalasia / motility disorder ___ Hiatal hernia ___
Stomach ulcer ___ Pancreatic disease ___
Cirrhosis / Hepatitis ___ Incisional / Abdominal hernia ___
Abnormal Liver findings ___
Enlarged liver ___ elevated enzymes ___ NASH ___ liver failure ___
Other _____
NONE ___

Musculoskeletal / Autoimmune:

Back pain ___ Joint pain ___
Fibromyalgia ___ Lupus / Scleroderma ___
Other _____
NONE ___

Neurologic:

Seizures or convulsions ___ Multiple sclerosis ___
Pseudotumor Cerebri ___
Other _____
NONE ___

Blood / Lymphatic:

HIV / AIDS ___ Lymphoma / Leukemia ___
Prior blood transfusion ___ Bleeding / Clotting disorder ___
Other _____
NONE ___

Psychiatric:

Please tell us honestly about any mental health diagnosis and / or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will all be kept confidential.

Alcoholism / Substance Abuse ___ Post Traumatic Stress Disorder (PTSD) ___
Anxiety ___
Bipolar disorder (manic-depression) ___ Depression ___
Schizophrenia / Schizoaffective Disorder ___ Borderline Personality Disorder ___
Sexual abuse ___ Mental / Emotional abuse ___
Physical abuse ___
Other psychiatric illness or condition? Please describe here_____
_____

NONE ___

Have you ever been hospitalized for psychiatric problems?
YES ___ NO ___
If yes, for what condition and when? _____

Have you ever been in a chemical dependency program?
YES ___ NO ___
If yes when? _____

Have you ever attempted suicide?
YES ___ NO ___
If yes when? _____

Are you currently seeing a counselor/psychiatric professional?
YES ___ NO ___
If yes, for what condition(s)? _____

Patient Signature:_____ Date:_____