the center for medical weight loss

CMWL FORMS MANUAL

The following forms are provided so that you can use them as a guide to customizing your own, personalized office forms. Please feel free to use them as is, or modify them to fit your practice.

If you have any questions or need assistance, please don't hesitate to call us at 513-860-0371.

Statement of Philosophy

1. Obesity is a chronic disease, which requires a lifelong treatment.

2. Obesity is a disease process with a physiological cause, like diabetes or hypertension. It is **not** a result of "**weakness"** or **"lack of willpower"** on the part of the patient.

3. Obese individuals have a right to healthcare that is safe and fits their lifestyle. It should recognize and respect their individual, physical, social, spiritual, psychological and economic needs.

WEIGHT CONTROL
EXPECTATIONS QUESTIONNAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form

has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us? (**Please circle all that apply to you)** Newsday, Daily News, Magazine, Radio, Google, mdbethin.com, liwli.com, Parent, Friend, Doctor, Drive by or Other ……

How much weight do you expect to lose? ……. Each week? …… Each month? ……

What will happen if you don't lose that much or that fast? How will you react? ……..

……..

If your weight loss slows down markedly or even completely stops for a while, will you understand the difference between fat loss and water loss? ……

What size clothes do you expect to be able to wear when you reach your goal weight?

…….

What do you expect from us (your medical counselors)? Be specific: ……..

…….

Will it change your life in any way (for better or worse) when you reach your goal weight? ……

Do you expect to be doing anything you are not doing now? (describe in detail) …….

…….

Do you expect to STOP doing something you ARE DOING NOW? (describe in detail)

……

Will you be able to handle compliments about how you look when you are of normal size? ……

Will your “new” normal weight self” pose a threat to your relationship with “significant others?” (how specifically?) ……

How will family and friends respond to the “new you?”……

Do you expect to get a better job? ……

Will you get more respect from other people?(Who specially)…….

Will you feel comfortable with these altered responses from others? ……..

Will you be expected to perform better at work (or at home)? …….

Will you have to be more sociable than you are now? …….

Will you have to assume any new responsibilities (please describe)? …….

……

What will happen if some of your expectations don’t come true? What might you do?

……

What do you expect to have to do to maintain weight the same? …….

……

Will you continue to watch your food intake? …….Exercise? ……...…....

Continue with professional medical monitoring? …….For about how long?.....

Do you have any other expectations than those listed above?.....Specifically, what are they? Please describe them in detail …….....

……

……

……

Patient Name:_____Date:_____

Appointment Cancellation Policy

As a result of not having any available appointments in our schedule and in order to best serve our patients, the following policy is necessary:

Their will be a $50 charge if you fail to cancel your scheduled appointment in advance. Your credit card will or you will be billed $50 on the day of your visit if you fail to cancel your appointment prior to the scheduled time.

Payment in full is necessary prior to any treatments being rendered. The payment is non-refundable and non-transferable. In the event that you are unable to complete a pre-paid treatment regimen you could finish the treatment at a later date. (Up to one year from your last appointment)

By signing below I agree that I was informed of this office policy.

X_____

_____
(Patient name)

Date _____/_____/_____

Initial Physical Exam DOB_____

Name _____ Age:_____ Date:_____

Vital Signs: BP (sitting) _____ Pulse _____ Temperature _____ LMP _____

Height(w/o shoes) _____in. Weight(w/o shoes) _____lbs. Preliminary Goal Weight ____

SUBJECTIVE:

PMH: PSH: MEDICATIONS: DIET HISTORY

SOCIAL HISTORY: ALLERGIES: FH:

Head [ ] nl _____ **Hair [ ] nl _____**
Eyes [ ] nl _____ **Ears [ ] nl _____**
Throat [ ] nl _____ **Teeth [ ] nl _____**
Neck [ ] nl _____ **Heart [ ] nl _____**
Lungs [ ] nl _____ **Back [ ] nl _____**
Abdomen [ ] nl _____ **Neuro [ ] nl _____**
Extremities [ ] nl _____ **Skin [ ] nl _____**
Pelvic and Breast Exam not performed

ECG Completed and Reviewed [ ] [ ] Normal [ ] Abnormal
Body Composition Analysis Completed and Reviewed [ ] (see copy on chart)

DX: _____

[ ] Diet Discussed _____

_____

Labs Ordered YES NO if no were medial records obtained? YES NO
[ ] Exercise Prescription Discussed _____

[ ] Medication Prescribed _____

[ ] Side Effects Discussed _____

[ ] Informed Consent Signed
Return in _____ weeks for follow-up visit No1. X _____

Informed Consent For A Low Calorie Diet

We want you to know…

When you decided to learn more about managing your weight, you took an important step toward improving your health. The health professional who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight.

The calorie deficit and portion-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974.

Your role…

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem eating activity and lifestyle patterns so your health care professional can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your health professional has outlined for you, including assessment, treatment, and maintenance phases.
- Work with your health care professional and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your appointments regularly if appropriate, and following your diet and exercise prescription.
- Allow your health care professional to share information with your personal physician.
- Make and keep follow-up appointments with your physician and have any blood test taken or any other diagnostic measure made which your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by your health care professional and your physician.
- It is vitally important for you to advise the clinic staff on ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the physician can determine if you should be seen more often. Keeping the center informed of any questions or symptoms you have, affords the best chance of intervening before a problem becomes serious.

Potential benefits…

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:

- Lower blood pressure, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see our physician as needed to have your need for these medications reassessed. Our health care professional will share your results with your physician on a regular basis so the physician is informed about your progress.

Other benefits my also be obtained. Increasing activity level can favorably affect the above conditions and has the additional benefit of helping you sustain weight loss. Weight loss and increased activity provide important psychological and social benefits, as well.

Possible side effects…

The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these conditions occur, additional medical or surgical treatment may be necessary. In addition it is conceivable other side effects could occur that have not been observed to date.

Reduced Weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. In addition, your body makes some other adjustments in physiology. Some of these are responsible, in some participants for rapid improvements in blood pressure and blood sugar; other adjustments may be experienced as temporary side effects or discomforts. These may include an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism, sensitivity to cold, a slower heart rate , dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern dry and brittle hair or hair loss. These responses are temporary and resolve when calories are increased after the period of weight loss.

Reduced Potassium Levels. The calorie level you will be consuming is 800 or more calories per day, and it is important that you consume the calories that have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

Gallstones. Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstone (pain, diagnosed stoned and/or surgery) in individuals 30 percent or more over desirable body weight (50 pounds or more overweight) not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 0-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals entering a weight loss program showed that as many as 1 in 10 had “silent” gallstones

at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight—especially rapidly—may increase the chances of developing stones or sludge and/or increasing the size of existing stones within the gallbladder. Should any symptoms develop (the most common are fever, nausea and a cramping pain in the right upper abdomen or if you know or suspect that you may already had gallstones), let your physician and health care professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. A drug (Actigall) is currently available that may help prevent gallstone formation during rapid weight loss. You may wish to discuss Actigall with your primary care or weight management physician for more information.

Pancreatitis. Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the right upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis are long- term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your health care professional and physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

Binge Eating Disorders. Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one study to increase binge eating episodes temporarily. Several other studies demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The risk of weight regain…

Obesity is a chronic condition, and the majority or overweight individuals who lose weight has a tendency to regain all or some of it over time. Factors which favor maintaining a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs.

Successful treatment may take months or even years. Medical studies of calorie deficit/portioned-controlled diets (including modified fasting) have shown varying results for percentage of patients who maintain weight loss. In some studies, the percentage has been fewer than 5% of the patients after five years. A group of patients who have been followed for 3 years show that patients have maintained about one half of initial weight loss. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program.

Sudden Death. Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some tiredness, psychological problems, medication allergies, high blood pressure, rapid heart rate and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Your rights and confidentiality…

You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure the physician knows you are discontinuing treatment and to verify your physician is able to assume medical care for you after you leave treatment.

By signing this informed Consent, you state: I understand the information about my treatment in the weight management program offered by the center identified below is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others, I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

Resale of Products…

The Center For Medical Weight Loss products purchased through this weight management program, including Multivitamins, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any of The Center For Medical Weight Loss products purchased through this weight management program.

I, the undersigned, have reviewed this information with my health care professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.

_____ _____

Participant Signature **Date**

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed program and have answered any questions posed by the patient. I believe the patient/relative/guardian fully understands what I have explained and answered.

_____ _____

Physician Signature **Date**

Nutritional Product Payment Agreement

Payment is necessary for all nutritional products in full prior to services being rendered for the medical weight loss program. The payment is non-refundable and non-transferable. In the event that you are unable to complete the program, you will be able to complete the unused portion at a later date (up to 1 year from your last appointment). Food is unexchangeable due to Department of Health Regulations.

I agree to the above:

X_____

Name

Please provide us with the name and telephone number of your primary care physician, so that we could keep him/her informed of your progress.

Physician Name _____

Telephone # _____

MEDICAL HISTORY

Name:_____ Date:_____/_____/_____

Please fill this out and mail it back with your other new patient paperwork. This is a part of your medical history and will be kept on file as a part of your chart. All the information contained in this form will not be released to any person or entity with your written consent.

Your primary care provider is:_____

PAST MEDICAL HISTORY

Please list all of your medical problems:

Diagnosis	Date	Doctor
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		

PAST SURGICAL HISTORY

Please list ALL of the operations you have had in the past:

Type	Date
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	
➢ _____	

the center for medical weight loss

REGISTRATION FORM

(Please Print)

Today's date:	Family Doctor

PATIENT INFORMATION

Patient's last name: First: Middle: Street address: City State Zip		Gender: ☐ M ☐ F Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	

Home phone: Cell phone:	Email: Social Security #	Nickname:

Employer Name	Employer Phone:		

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Referring Provider address and telephone:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southwest Ohio Pain Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Muhammad Munir, M.D. or Rajpal Kohli, M.D. to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

> "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.
>
> "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
>
> "As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness,

tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE DOCTOR or NURSE PRACTICIONER NOW BEFORE SIGNING THIS CONSENT FORM.

DATE:_____
TIME:_____

PATIENT: _____

VI. HEALTH CARE PROVIDERS DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature