BARIATRIC PATIENT CONTRACT

Welcome to our Bariatric Program designed to optimize your success toward a new and healthy lifestyle. To achieve this goal, we strongly request your active participation in this long-term process. Therefore, we have compiled a list of activities and requirements viewed as essential to accomplishing our mutual goals. Please review and sign this document acknowledging that you understand our recommendations and are willing to fulfill your obligation.

- Maintain good communication with your primary care physician (PCP), and bariatric team, and all other essential health care providers.
- Keep all scheduled follow-up appointments.
- Agree to long-term follow-up with Bariatric Program (10-years).
- Obtain fasting laboratory data as scheduled.
- Take medications and nutrient supplements as recommended. Do not discontinue medications without MD approval.
- Safely incorporate daily physical activity and exercise under the direction of your surgeon, PCP and bariatric team members.
- Discontinue smoking or any other non-healthy habits.
- For women of child bearing age, avoid pregnancy for 18-24 months after your operation and consult with your ob-gyn physician for a pre-pregnancy evaluation. Birth control pills may NOT be effective, therefore, you should use two methods of birth control.
- Avoid plastic surgery for excess skin removal for 18-24 months following surgery to allow stabilization of your weight loss.
- Follow recommended diet guidelines.
  - Healthy food selections
  - Allow time for the meal period
  - Stay hydrated
    - Monitor fluid intake
    - Monitor urine output (frequency and color)
  - Monitor portion sizes (weigh and measure liquid and food as needed)
  - Read package labels (stay within the guidelines established)
  - Maintain daily food records prior to each nutrition follow-up visit

Patient Name: ________________________________ Date: _________________
Patient Signature: _____________________________ Date: _________________
Bariatric Team Member: _______________________ Date: _________________
Surgeon’s Signature: __________________________ Date: _________________