Patient Contract

Understanding pregnancy, fertility and weight loss surgery

This Patient Contract is provided to ensure that you fully understand that women of childbearing age who have had weight loss surgery must take special precautions in avoiding pregnancy for a designated period of time after weight loss. Weight loss due to bariatric surgery often increases fertility in those whom have had difficulty conceiving in the past. With that in mind, please complete following.

I. Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statement.

_________ 1. I understand that one of the goals of this Patient Contract is to help my bariatric team members understand that I commit to avoid pregnancy until discussed and cleared with my surgeon and obstetrician.

_________ 2. I understand and agree that pregnancy should not be attempted until weight loss and nutritional intake have stabilized.

_________ 3. As a woman of childbearing age who seeks to have weight loss surgery, I commit to using two reliable birth control methods during the period of rapid weight loss.

_________ 4. I understand that maternal malnutrition may impair normal fetal development.

_________ 5. When I become pregnant, I understand the importance of prenatal vitamins and other supplements and agree to take the prescribed amounts prior to and for the entire pregnancy as recommended by my dietician or obstetrician.

_________ 6. I expect to delay pregnancy for *at least* 18 months after surgery.

_________ 7. I agree to discuss my procedure, the need for birth control, and my commitment to avoid pregnancy with my significant family members.

_________ 8. When I become pregnant, I can expect that my surgeon and obstetrician will order special testing and treatments that could result in additional costs.

Date	Time	Signature of Patient Or Authorized Representative	Relationship of Authorized Rep.

WITNESS:

- ☐ The Patient/Authorized Representative has read the entire form or had it read to him/her
- ☐ The Patient/Authorized Representative express understanding of the form
- ☐ The Patient/Authorized Representative has no further questions

Date	Time	Signature of Witness	Printed Name

Title or Relationship to Patient