Patient Contract

Vitamin and Protein Supplements

This Contract outlines your understanding and responsibilities. It is provided to ensure that you fully understand how valuable you are to your success. This agreement is important for you to understand because if you fail to meet the responsibilities described below, your surgical team will be required to regretfully terminate the relationship and begin the process to refer your care to another surgeon. Please let us know if you have questions. Review the statements and initial on the line next to the numbered paragraph which will evidence your understanding.

_____ 1. I understand that the Roux-en-Y Gastric Bypass is both malabsorptive and restrictive.

_____ 2. I understand that malabsorption is not typically a problem after laparoscopic adjustable band, but restriction could pose nutritional problems.

_____ 3. I understand that I am expected to keep food diaries because they help assess nutritional problems, protein/vitamin intake or disordered eating behavior.

_____ 4. I can expect lab work done at least annually for the rest of my life, and it is my responsibility to have this done as directed.

_____ 5. I understand the importance of protein to health and recognize poor protein intake could lead to hair loss.

_____ 6. The malabsorptive and restrictive nature of gastric bypass predisposes me to protein and vitamin deficiencies.

_____ 7. I agree to take B-complex and chewable calcium as directed daily.

_____ 8. Attention to protein and vitamin supplement begins before surgery and continues for life.

_____ 9. I agree to take thiamine supplements along with a quality multivitamin each day as directed by my health care team.

_____ 10. Some patients are protein/vitamin challenged before surgery, and therefore dietary education and nutritional changes must occur even before surgery.

_____ 11. It is my responsibility to ask questions when I am uncertain about vitamins and protein supplements.

_____ 12. I understand that if I fail to accept my responsibility for care as directed by the team, I could be terminated from their care.

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