Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ / 20_ _ Initials: _____

For office use only.

Discharge (DS) – Version 08/28/2006

Patient ID __ __ __ - __ __ __ __- __ __ __ __ __

Form Completion Date __ __ / __ __ / 20 __ __
mm dd yy

Surgeon certification number: __ __ __ __ __

Date of Surgery __ __ / __ __ / **20** __ __
mm dd yy

1. Were any post-operative anticoagulation therapies received prior to discharge? ☐ 0. No ☐ 1. Yes

If yes,

			Prophylactic (preventative) Use?				Therapeutic (as treatment) Use?			
No	Yes		No	Yes	# of Days	Times per day	No	Yes	# of Days	Times per day
☐	☐	5000 units sub-cutaneous heparin	☐	☐	____	____	☐	☐	____	____
☐	☐	Other dose heparin (Dose: _____ units)	☐	☐	____	____	☐	☐	____	____
☐	☐	Low molecular weight heparin If yes,	☐	☐	____	____	☐	☐	____	____
		Specify dose: ☐ 20 mg ☐ 40 mg ☐ 60 mg ☐ Other (Specify: _____ mg)								
☐	☐	Other Anticoagulant If yes,	☐	☐	____	____	☐	☐	____	____
		Specify name: _____ Specify dose:_____ ☐1.mg ☐2. units								

2. Post-operative pain management (*check no or yes for each*):

No	Yes		No	Yes	
☐	☐	Thoracic epidural	☐	☐	Intermittent IV narcotics
☐	☐	Abdominal epidural	☐	☐	Tylenol
☐	☐	Patient controlled anesthesia (PCA) pump	☐	☐	Ketorolac
☐	☐	Oral narcotics	☐	☐	Other (Specify: _____)

3. Patient disposition after surgery: ☐ 1. ICU ☐ 2. Floor with Telemetry ☐ 3. Floor without Telemetry ☐ 4. Same day discharge

If ICU,

3.1 Specify number of days of intubation after surgery: _____ *(day of surgery is defined as day zero)*

3.2 Was the patient reintubated? ☐ 0. No ☐ 1. Yes → If yes, # of times: _____

4. Was the patient discharged more than 30 days AFTER initial surgery? ☐ 0. No ☐ 1. Yes

5. Date of hospital discharge (or date of death if patient died prior to discharge): __ __ / __ __ / 20 __ __
m m dd yy

6. Intended discharge location:

☐ 1. Home
☐ 2. Rehabilitation facility
☐ 3. Skilled nursing facility
☐ 4. Other hospital
☐ 5. Was not discharged (patient died prior to discharge)

7. Did the patient have any in-hospital Post-Operative Complications prior to discharge? ☐ 0. No ☐ 1. Yes

If yes,

		If patient was discharged more than 30 days AFTER initial surgery, check this box if complication occurred WITHIN 30 days of surgery
7.1.	Re-operation ☐ 0. No ☐ 1. Yes If yes, 7.1.1 Specify reason for surgery *(check all that apply)*: No Yes ☐ ☐ Intestinal obstruction ☐ ☐ Subsequent cholecystectomy ☐ ☐ Anastomotic leak ☐ ☐ Other abdominal sepsis ☐ ☐ Pulmonary embolism ☐ ☐ Pneumonia ☐ ☐ Other respiratory failure ☐ ☐ Subsequent abdominoplasty No Yes ☐ ☐ Wound infection/evisceration ☐ ☐ Fluid or electrolyte depletion ☐ ☐ Vomiting or poor intake ☐ ☐ Gastric distension ☐ ☐ Strictures ☐ ☐ Bleeding ☐ ☐ Infection/fever ☐ ☐ Other (Specify:_____)	☐ within 30 days
7.2.	Gastrojejunostomy leak ☐ 0. No ☐ 1. Yes If yes, 7.2.1 Specify grade: ☐ 1. Minimal – small contained leak, patient asymptomatic ☐ 2. Moderate – moderate size forming collection, symptomatic, drain used. ☐ 3. Large – not contained, symptomatic, requires re-operation.	☐ within 30 days
7.3.	Jejuno-jejunostomy leak ☐ 0. No ☐ 1. Yes If yes, 7.3.1 Specify grade: ☐ 1. Minimal – small contained leak, patient asymptomatic ☐ 2. Moderate – moderate size forming collection, symptomatic, drain used. ☐ 3. Large – not contained, symptomatic, requires re-operation.	☐ within 30 days
7.4.	Pancreatitis ☐ 0. No ☐ 1. Yes	☐ within 30 days
7.5.	Post operative bleeding ☐ 0. No ☐ 1. Yes If yes, 7.5.1 Specify location: No Yes ☐ ☐ Upper intestine ☐ ☐ Lower intestine No Yes ☐ ☐ Intra-peritoneal ☐ ☐ Unknown ☐ ☐ Other: (Specify:_____) 7.5.2 Specify # of units of blood required: _____	☐ within 30 days

7.6. Abdominal abscess ☐ 0. No ☐ 1. Yes ☐ within 30 days
If yes,

7.6.1 Specify location:

No	Yes	
☐	☐	Left upper quadrant
☐	☐	Subhepatic
☐	☐	Lower abdomen
☐	☐	Other (specify: _____)

7.7. Esophageal injury ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.8. Wound infection ☐ 0. No ☐ 1. Yes ☐ within 30 days
(Cellulitis around incision site accompanied by fever)

7.9. Fascial dehiscence ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.10. Seroma of wound ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.11. Small bowel obstruction ☐ 0. No ☐ 1. Yes ☐ within 30 days
If yes,

7.11.1 Specify obstruction:
- ☐ 1. Partial obstruction
- ☐ 2. Complete obstruction

7.11.2 Specify cause:
- ☐ 1. Internal hernia
- ☐ 2. Adhesions
- ☐ 3. Anastomotic anatomy
- ☐ 4. Obstructed JJ Anastomosis
- ☐ 5. Unknown
- ☐ 6. Other (Specify: _____)

7.12. Stomal/gastric outlet obstruction ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.13. Stomal stenosis ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.14. GI ulcer(s) ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.15. Ateletasis (significant) ☐ 0. No ☐ 1. Yes ☐ within 30 days
(Diagnosis by chest X-ray accompanied by fever)

7.16. Pneumothorax ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.17. Pleural effusion ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.18. Pulmonary embolism ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.19. Deep vein thrombosis ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.20. Pneumonia ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.21. Respiratory failure requiring intubation ☐ 0. No ☐ 1. Yes ☐ within 30 days
If yes,

7.21.1 Specify cause:
- ☐ 1. ARDS
- ☐ 2. Pneumonia
- ☐ 3. PE
- ☐ 4. Other (Specify: _____)
- ☐ -3. Unknown

7.22. Renal/urinary tract infection ☐ 0. No ☐ 1. Yes ☐ within 30 days

7.23 Renal failure ☐ 0. No ☐ 1. Yes ☐ within 30 days
If yes,

7.23. Specify type of diagnosis *(check "no" or "yes" for each)* :

No	Yes	
☐	☐	Oliguric/anuric
☐	☐	Creatinine

7.24. TIA	□ 0. No	□ 1. Yes	□ within 30 days
7.25. Stroke	□ 0. No	□ 1. Yes	□ within 30 days
If yes,			
7. 25.1 Specify type of diagnosis: □ 1. Ischemic □ 2. Hemorrhagic			
7.26. Urinary retention	□ 0. No	□ 1. Yes	□ within 30 days
7.27. New decubitus ulcers (bed sores)	□ 0. No	□ 1. Yes	□ within 30 days
7.28 Rhabodomyolysis (*defined as CPK's of 5000 or more*)	□ 0. No	□ 1. Yes	□ within 30 days
7.29. Jaundice	□ 0. No	□ 1. Yes	□ within 30 days
7.30. Hepatitis	□ 0. No	□ 1. Yes	□ within 30 days
7.31. Liver failure	□ 0. No	□ 1. Yes	□ within 30 days
7.32. Acute cholecystitis/bilaric colic	□ 0. No	□ 1. Yes	□ within 30 days
7.33. Common bile duct stones/cholangitis	□ 0. No	□ 1. Yes	□ within 30 days
7.34. Arrhythmia	□ 0. No	□ 1. Yes	□ within 30 days
7.35. Persistent Tachycardia	□ 0. No	□ 1. Yes	□ within 30 days
7.36. Myocardial infarction	□ 0. No	□ 1. Yes	□ within 30 days
7.37. Cardiac arrest	□ 0. No	□ 1. Yes	□ within 30 days
7.38. Death	□ 0. No	□ 1. Yes	□ within 30 days
7.39 Other event that resulted in an unexpected course of action (Specify: _____)	□ 0. No	□ 1. Yes	□ within 30 days

Discharge Form (DS)

PURPOSE:	The DS form consists of specific questions related to the hospital stay/post-surgical bariatric procedure.
PERSON(S) RESPONSIBLE:	Surgeon
SOURCE(S) OF INFORMATION:	Surgeon, Coordinator
TIME OF ADMINISTERING FORM:	At time of discharge
GENERAL INSTRUCTIONS: (Patient)	N/A
GENERAL INSTRUCTIONS: (Clinician)	**Patient ID:** Record the patient's ID number in the top left hand corner of the form. **Form Completion Date:** Record the date (mm/dd/20yy) on which the surgeon is completing the questionnaire. This should be the same date as the surgery. **Certification Number:** Record the certification code of the surgeon completing the form. Only LABS certified surgeons can complete this form.
SCORING ALGORITHM:	N/A

DATA SECTION	COMPLETION INSTRUCTIONS
Post-Operative anticoagulation therapy received	1. Were any post-operative anticoagulation therapy received? Check "yes" if any post-operative anticoagulation therapy was received by the patient. If yes, specify whether or not any of the following items were received by the patient. • 5000 units sub-cutaneous heparin • Other dose heparin (if other specify dose in units) • Low molecular weight heparin, (if low molecular weight heparin, specify dose as 20 mg, 40 mg, 60mg or other dose – specify other dose) • Other anticoagulant was used. If an other anticoagulant was used, specify name/dose and whether the dose was mg or units. If any of the items are checked "yes" specify the number of days received.
Pain management	2. Primary post-operative pain management: Check "no" or "yes" to whether the following pain management procedures were used. • Thoracic epidural • Abdominal epidural • Pain controlled anesthesia (PCA) pump • Oral narcotics • Intermittent IV narcotics • Tylenol • Ketorolac • Other (Specify other).
Patient disposition	3. Patient disposition after surgery: Specify if the patient was placed in the ICU, on the floor with a heart monitor or on the floor without a heart monitor. 3.1 Specify the number of days of intubation after surgery was completed and 3.2 Specify whether or not the patient was reintubated. If the patient was reintubated, specify the number of times. 4. Was the patient discharged more than 30 days AFTER initial surgery: Check "yes" if the patient remained hospitalized more than 30 days after the initial surgery otherwise check "no." 5. Date of hospital discharge (or date of death if patient died prior to discharge): Specify the date of hospital discharge or death date as listed as mm/dd/yy . 6. Discharge Location: Record the location to which the patient was discharged from the hospital. Home = patient's primary residence or other residence not equipped with specialty healthcare facilities, such as home of parent, child or friend; Rehabilitation facility = any licensed rehabilitation facility; Skilled nursing facility = An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by the Joint

	Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the health plan to meet the reasonable standards applied by any of the aforesaid authorities; Other Hospital = a hospital other than the one where the patient underwent initial bariatric surgery; Was not discharged = patient died prior to discharge.
Post-Operative complications	7. Did the patient have any in-hospital Post-Operative complications: Check "yes" if the patient had any post-operative complications, check no otherwise. **Special Note: If the patient was discharged more than 30 days AFTER initial surgery, check the box for each complication that occurred WITHIN 30 days of surgery for each post-operative complication.** 7.1 Re-operation – Any event that lead to a return to the operating room for a procedure. 7.1.1 If re-operation, specify the reason(s) for the re-operation (check "no" or "yes" for each). 7.2 Gastrojejunostomy leak – Defined as loss of fluid at the site of a previous anastomosis of the GJ believed to lead to overwhelming infection. 7.2.1 If Gastrojejunostomy leak, specify grade as: Minimal – defined as small contained leak, patient asymptomac. Moderate – moderate size formatting collection, symptomatic, drain used. Large – not contained, symptomatic, requires re- operation. 7.3 Jejuno-jejunostomy leak– Defined as loss of fluid at the site of a previous anastomosis of the JJ believed to lead to overwhelming infection. 7.3.1 If Jejuno-jejunostomy leak, specify grade as: Minimal – defined as small contained leak, patient asymptomac. Moderate – moderate size formatting collection, symptomatic, drain used. Large – not contained, symptomatic, requires re- operation. 7.4 Pancreatitis – Defined as an inflammation or infection of the pancreas 7.5 Post operative bleeding – Defined as loss of blood that occurs internally (blood leaks from blood vessels inside the body), externally through a natural opening. *If the patient had post-operative bleeding:* 7.5.1 specify location (check "no" or "yes" for each) as upper intestine, lower intestine, intra-peritoneal. 7.5.2 Specify number of units of blood required in cubic centimeters (cc)

7.6 Abdominal abscess – Defined as infected pockets of fluid that occur within the abdominal cavity.

If the patient had an abdominal abscess:
7.6.1 Specify location (check "no" or "yes" for each) as left upper quadrant, subhepatic, or lower abdomen.

7.7 Esophageal injury – Defined as an injury to the esophagus.

7.8 Wound infection – defined as cellutitis around incision site accompanied by fever.

7.9. Wound dehiscence – Breach/breakdown of the fascial wound closure.

7.10 Seroma of wound – Defined as a tumor-like collection of serum in the wound tissues.

7.11 Small bowel obstruction – Defined as partial or complete blockage of the bowel that results in the failure of the intestinal contents to pass through.

If the patient had a small bowel obstruction:
7.11.1 Specify obstruction as partial obstruction or complete obstruction.
7.11.2 Specify Cause as Internal hernia, adhesions, or anastomic anatomy

7.12 Stomal obstruction – Defined as obstruction of the stoma.

7.13 Stomal Stenosis – Defined as Narrowing or stricture of a duct or canal relating to the stoma.

7.14 GI Ulcer(s) – Defined as an open sore, or lesion, found in the GI area.

7.15 Ateletasis (significant) – Defined by diagnosis by chest X-ray accompanied by fever)

7.16 Pneumothorax – Defined as the presence of gas or air in the pleural cavity that requires medical intervention.

7.17 Pleural effusion – Defined as an accumulation of fluid between the layers of the membrane that lines the lungs and chest cavity.

7.18 Pulmonary embolism – Defined as blockage of an artery in the lungs by fat, air, clumped tumor cells, or a blood clot.

7.19 Deep Vein Thrombosis – Defined as a blood clot that forms in a vein deep in the body

7.20 Pneumonia – Defined as Inflammation of the lungs caused by an infection.

7.21 Respiratory Failure – Defined as failure of the respiratory system in one of both of its gas exchange functions: Oxygenation and carbon dioxide to that area.

If the patient had respiratory failure:
7.21.1 Specify cause: as either ARDS, pneumonia, PE or unknown.

7.22 Renal/urinary tract infection – Defined as an infection that begins in the renal/urinary system.

7.23 Renal Failure – Defined as sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, and to conserve electrolytes.

If the patient had Renal Failure
7.23.1 Specify type of diagnosis: as Oliguric/anuric or Creatinine

7.24 TIA – Defined as an interruption of the blood supply to any part of the brain, that produces stroke-like symptoms but no lasting damage.

7.25 Stroke – Defined as interruption of the blood supply to any part of the brain, resulting in damaged brain tissue.

If the patient had a stroke
7.25.1 Specify type of diagnosis: as ischemic or hemorrhagic

7.26 Urinary retention – Defined as the abnormal holding of urine in the bladder.

7.27 Necubitus ulcers (bed sores) – defined as bed sores.

7.28 Rhabodomyolysis – Defined as CPK's of 5000 or more

7.29 Jaundice – Defined as a yellow color in the skin, the mucous membranes, or the eyes.

7.30 Hepatitis – Defined as an inflammation of the liver, including a viral or bacterial infection, liver injury caused by a toxin (poison), and an attack on the liver by the body's own immune system.

7.31 Liver failure – Severe deterioration in the liver function.

7.32 Acute cholecystitis – Defined as sudden inflammation of the gallbladder that causes severe abdominal pain

7.33 Common bowel stones/cholangitis – Acute infection of the biliary tract.

7.34 Arrhythmia – Defined as resulting in significant change in blood pressure and pharmacological intervention.

7.35 Persistent Tachycardia –

7.36 Myocardial infarction – Heart muscle dies or is permanently damaged because of an inadequate supply of oxygen to that area.

7.37 Cardiac arrest – Defined as abrupt cessation of heartbeat requiring medical intervention (resuscitation).

7.38 Death – defined as patient death.

7.39 Other event that resulted in an unexpected course of action.