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

For office use only.

Pre-operative Form (PO1) – Version: 12/15/2006

Patient ID __ __ __ - __ __ __ __- __ __ **Evaluation Date** __ __ / __ __ / 20 __ __
mm dd yy

Certification number: ___ ___ ___ ___ ___

To be completed on all patients who provide informed consent. *Clinical sites that have the proper IRB approval should also complete this section for all patients who decline to provide informed consent.*

1. Consent to LABS 1: □ 0. No → (if no)

1.1 Reason for refusing (check all that apply):
- □ General lack of interest.
- □ Does not want to be bothered.
- □ Lack of trust (e.g. that personal information will remain confidential).
- □ Concerned that information provided will impact ability to have surgery.
- □ No perceived personal benefit from participating.
- □ Does not want to be included as subject in medical research.
- □ Other (Specify: _____)
- □ Unknown

1.2 Patient's age: _____ (years)

□ 1. Yes → (if yes)

1.3 Date of consent: __ __ / __ __ / 20 __ __
mm dd yy

1.4 Patient's date of birth: __ __ / __ __ / 19 __ __
mm dd yy

2. Gender:
- □ 1. Male
- □ 2. Female

3. Height: ____ (ft), ____ ____ (in)

3.1 How was height measured?
- □ 1. Standing
- □ 2. Lying Flat
- □ 3. Estimate

4. Weight: __ __ __ (lbs)

4.1 How was weight measured?
- □ 1. Tanita Scale
- □ 2. Other Scale
- □ 3. Last available bed weight
- □ 4. Estimate

5. Ethnicity:
- □ 0. Hispanic
- □ 1. Non-Hispanic

6. Race *(check all that apply)* :
- □ White or Caucasian
- □ Black or African-American
- □ Asian
- □ American Indian or Alaska Native
- □ Native Hawaiian or other Pacific Islander
- □ Other (specify _____)

***** Continue ONLY if there is written informed consent for LABS-1. Otherwise, do not complete the rest of this form. *****

7. Previous obesity surgery OR surgery performed on the esophagus, stomach or proximal small intestine not for the purpose of weight loss? ☐ 0. No ☐ 1. Yes

7.1 If yes, specify (check "no" or "yes" for each item):

No	Yes		Number of previous surgeries (including revisions and reversals)	Date of most recent surgery
☐	☐	Gastric Bypass (Roux-en-Y)	__ __	_ _/_ _/_ _ _ _
☐	☐	Biliopancreatic div. (BPD)	__ __	_ _/_ _/_ _ _ _
☐	☐	Biliopancreatic div. w/switch (BPDS)	__ __	_ _/_ _/_ _ _ _
☐	☐	Adjustable Gastric Band (AGB)	__ __	_ _/_ _/_ _ _ _
☐	☐	Vertical Banded Gast. (VBG)	__ __	_ _/_ _/_ _ _ _
☐	☐	Sleeve Gastrectomy (SG)	__ __	_ _/_ _/_ _ _ _
☐	☐	Prior surgery performed on the esophagus, stomach or proximal small intestine NOT for the purpose of weight loss.	__ __	_ _/_ _/_ _ _ _
☐	☐	Other previous obesity surgery 1 (Specify: _____)	__ __	_ _/_ _/_ _ _ _
☐	☐	Other previous obesity surgery 2 (Specify: _____)	__ __	_ _/_ _/_ _ _ _

8. Smoking status: ☐ 1. Never smoked ☐ 2. Current: → Age started regularly: _____ Average packs/day: ____ ☐ 3. Former: → Age started regularly: _____ Age quit: _____ Average packs/day: _____

☐ 0. No ☐ 1. Yes

9. Is this patient a good candidate for LABS-2?

9. 1 If no, specify why (check "no" or "yes" for each item):

No	Yes		No	Yes		No	Yes	
☐	☐	Lives too far away	☐	☐	Prior bariatric surgery	☐	☐	Unable to communicate with study staff
☐	☐	Follow-up too burdensome	☐	☐	Unlikely to comply with protocol	☐	☐	Reading difficulty/illiteracy
☐	☐	Not interested				☐	☐	Other (Specify:_____)
☐	☐	< 14 days notice of surgery						

10. Planned procedure:

☐ 1. Gastric bypass (Roux-en-Y)
☐ 2. Biliopancreatic diversion (BPD)
☐ 3. Biliopancreatic diversion with Doudenal Switch (BPDS)
☐ 4. Laparoscopic adjustable gastric band (LAGB)
☐ 5. Sleeve gastrectomy-initial stage
☐ 6. Sleeve gastrectomy- second stage → ☐ 1. Gastric bypass (Roux-en-Y) ☐ 2. BPD ☐ 3. BPDS
☐ 7. Other (Specify: _____)
☐ 8. Banded Gastric bypass (Gastric bypass + non-adjustable band)
☐ 9. Vertical Banded Gastroplasty
☐ -3. Unknown at this time

11. Planned approach: □ 1. Laparoscopic □ 2. Open □ -3. Unknown

12. Is the planned procedure a revision? □ 0. No □ 1. Yes
If yes,

12.1 Patient status at time of previous procedure:	□ 1. LABS-1 Registered patient □ 2. Non-LABS-1 Patient

13. Is the planned procedure a reversal? □ 0. No □ 1. Yes
If yes,

13.1 Patient status at time of previous procedure:	□ 1. LABS-1 Registered patient □ 2. Non-LABS-1 Patient

14. Most recent laboratory value within 180 days:

	Blood Draw Date	Not done		Blood Draw Date	Not done
Fasting Glucose:_____ mg/dl	_ _ / _ _ / _ _ _ _	□	AST (SGOT):_____ IU/L	_ _ / _ _ / _ _ _ _	□
Creatinine:_____ mg/dl	_ _ / _ _ / _ _ _ _	□	Hematocrit: ___ ___.___%	_ _ / _ _ / _ _ _ _	□
Albumin: _____ g/dl	_ _ / _ _ / _ _ _ _	□	Triglycerides: _____ mg/dl	_ _ / _ _ / _ _ _ _	□
HbA1C: ___ ___ . ___ %	_ _ / _ _ / _ _ _ _	□	HDL: _____ mg/dl	_ _ / _ _ / _ _ _ _	□
Normal HbA1C **High** range: ___ ___.___%			Total Cholesterol: ____ mg/dl	_ _ / _ _ / _ _ _ _	□
ALT (SGPT): _____ IU/L	_ _ / _ _ / _ _ _ _	□	Alkaline Phosphatase: ____ IU/L	_ _ / _ _ / _ _ _ _	□

15. Medications in the past 90 days:
(check "no" or "yes" for each item)

No	Yes	
□	□	Therapeutic oral/IV immunosuppressant
□	□	Therapeutic anticoagulation
□	□	Narcotic
□	□	Statin or other lipid lowering agent
□	□	Antidepressant
□	□	Beta-blocker

16. Blood pressure: _____ / _____ (mmHg)
Systolic / Diastolic

16.1 How was blood pressure measured? □ 1. Mercury □ 2. Gauge □ 3. Electronic

17. Comorbidity	No	Yes		*If yes, check the <u>one</u> best response*
a. Hypertension	☐	☐	→	☐ 1. No medication ☐ 2. Single medication ☐ 3. Multiple medications
b. Diabetes	☐	☐	→	☐ 1. No medication ☐ 2. Single oral medication ☐ 3. Multiple oral medication ☐ 4. Insulin ☐ 5. Oral meds and insulin
c. CHF	☐	☐	→	NYHC: ☐ I ☐ II ☐ III ☐ IV ☐ *Unknown*
d. Asthma	☐	☐	→	☐ 1. History of Intubation ☐ 2. No History of Intubation

e. Functional Status ☐ 1. Can walk (length of grocery store aisle) 200 ft unassisted ☐ 2. Able to walk 200 ft with assist device (cane, walker) ☐ 3. Cannot walk 200 ft with assist device ☐ -3. Unknown

Comorbidity	No	Yes		Check "No" or "Yes" for each item	
				No	**Yes**
f. History of DVT/PE	☐	☐	→	☐	☐ Documented DVT
				☐	☐ Documented PE
				☐	☐ Venous edema w/ ulceration
g. Sleep apnea	☐	☐	→	☐	☐ C-pap/ Bi-pap
				☐	☐ Supplemental oxygen dependent
h. Ischemic Heart Disease	☐	☐	→	☐	☐ History of MI
				☐	☐ No active ischemia
				☐	☐ Abnormal EKG but unable to assess ischemia
				☐	☐ PCI, CABG
				☐	☐ Anti-ischemic medications
i. Pulmonary hypertension	☐	☐			

j. History of venous edema with ulcerations? ☐ 0. No ☐ 1. Yes

18. Are there any comorbid conditions the patient may have that could affect clinical outcome following bariatric surgery? ☐ 0. No ☐ 1. Yes

18.1 If yes, specify (*do not enter into database*):

_____

_____

_____

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

For office use only.

Pre-operative Update Form (PU1) – Version: 12/15/2006

Patient ID __ __ __ - __ __ __ __- __ __ **Evaluation Date** __ __ / __ __ / 20 __ __
mm dd yy

Certification number: ___ ___ ___ ___ ___ Consent Date __ __ / __ __ / 20 __ __
mm dd yy

Instructions: This form should be administered no more than 90 days prior to bariatric surgery and only if the LABS-1 Pre-operative (PO1) form was completed more than 90 days prior to surgery. Note that if this form was completed more than 30 days prior to surgery, the patient's weight must be recorded again within 30 days and entered into the database.

1. Weight: __ __ __ (lbs)

2. How was weight measured?
- □ 1. Tanita Scale
- □ 2. Other Scale
- □ 3. Last available bed weight
- □ 4. Estimate

If this form was completed more than thirty days before surgery, ONLY the patient's weight must be recorded again within thirty days of surgery.

2. Smoking status:
- □ 1. Never smoked
- □ 2. Current: → Age started regularly: _____ Average packs/day: _____
- □ 3. Former: → Age started regularly: _____ Age quit: _____ Average packs/day: _____

3. Planned procedure:
- □ 1. Gastric bypass (Roux-en-Y)
- □ 2. Biliopancreatic diversion (BPD)
- □ 3. Biliopancreatic diversion with Doudenal Switch (BPDS)
- □ 4. Laparoscopic adjustable gastric band (LAGB)
- □ 5. Sleeve gastrectomy-initial stage
- □ 6. Sleeve gastrectomy- → second stage
  - □ 1. Gastric bypass (Roux-en-Y)
  - □ 2. BPD
  - □ 3. BPDS
- □ 7. Other (Specify: _____)
- □ 8. Banded Gastric bypass (Gastric bypass + non-adjustable band)
- □ 9. Vertical Banded Gastroplasty
- □ -3. Unknown at this time

4. Planned approach: □ 1. Laparoscopic □ 2. Open □ -3. Unknown

5. Most recent laboratory value within 180 days of surgery:

	Blood Draw Date	Not done		Blood Draw Date	Not done
Fasting Glucose:_____ mg/dl	_ _ / _ _ / _ _ _ _	□	AST (SGOT):_____ IU/L	_ _ / _ _ / _ _ _ _	□
Creatinine:_____ mg/dl	_ _ / _ _ / _ _ _ _	□	Hematocrit: ___ ___.___%	_ _ / _ _ / _ _ _ _	□
Albumin: _____ g/dl	_ _ / _ _ / _ _ _ _	□	Triglycerides: _____ mg/dl	_ _ / _ _ / _ _ _ _	□
HbA1C: ___ ___ . ___ %	_ _ / _ _ / _ _ _ _	□	HDL: _____ mg/dl	_ _ / _ _ / _ _ _ _	□
Normal HbA1C **High** range: ___ ___.___%			Total Cholesterol: ____ mg/dl	_ _ / _ _ / _ _ _ _	□
ALT (SGPT): _____ IU/L	_ _ / _ _ / _ _ _ _	□	Alkaline Phosphatase: ____ IU/L	_ _ / _ _ / _ _ _ _	□

6. Medications in the past 90 days: (check "no" or "yes" for each item)

No	Yes	
□	□	Therapeutic oral/IV immunosuppressant
□	□	Therapeutic anticoagulation
□	□	Narcotic
□	□	Statin or other lipid lowering agent
□	□	Antidepressant
□	□	Beta-blocker

7. Blood pressure: _____ / _____ (mmHg) Systolic / Diastolic

7.1 How was blood pressure measured?
- □ 1. Mercury
- □ 2. Gauge
- □ 3. Electronic

8. Comorbidities:

Comorbidity	No	Yes		If yes, check the one best response
a. Hypertension	☐	☐	→	☐ 1. No medication ☐ 2. Single medication ☐ 3. Multiple medications
b. Diabetes	☐	☐	→	☐ 1. No medication ☐ 2. Single oral medication ☐ 3. Multiple oral medication ☐ 4. Insulin ☐ 5. Oral meds and insulin
c. CHF	☐	☐	→	NYHC: ☐ I ☐ II ☐ III ☐ IV ☐ *Unknown*
d. Asthma	☐	☐	→	☐ 1. History of Intubation ☐ 2. No History of Intubation

e. Functional Status ☐ 1. Can walk (length of grocery store aisle) 200 ft unassisted ☐ 2. Able to walk 200 ft with assist device (cane, walker) ☐ 3. Cannot walk 200 ft with assist device ☐ -3. Unknown

Comorbidity	No	Yes		Check "No" or "Yes" for each item	
				No	**Yes**
f. History of DVT/PE	☐	☐	→	☐	☐ Documented DVT
				☐	☐ Documented PE
				☐	☐ Venous edema w/ ulceration
g. Sleep apnea	☐	☐	→	☐	☐ C-pap/ Bi-pap
				☐	☐ Supplemental oxygen dependent
h. Ischemic Heart Disease	☐	☐	→	☐	☐ History of MI
				☐	☐ No active ischemia
				☐	☐ Abnormal EKG but unable to assess ischemia
				☐	☐ PCI, CABG
				☐	☐ Anti-ischemic medications
i. Pulmonary hypertension	☐	☐			

j. History of venous edema with ulcerations? ☐ 0. No ☐ 1. Yes

9. Are there any comorbid conditions the patient may have that could affect clinical outcome following bariatric surgery? ☐ 0. No ☐ 1. Yes

9.1 If yes, specify (*do not enter into database*):

_____

_____

_____

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

For office use only.

Operative Evaluation Form (OP1) – Version: 12/15/2006

Patient ID __ __ __ - __ __ __ __- __ __ **Form Completion Date** __ __ / __ __ / 20 __ __ (mm / dd / yy)

Surgeon Certification Number: ___ ___ ___ ___ ___

1. Date of Surgery __ __ / __ __ / 20 __ __ (mm/dd/yy)

2. Operative times: (military time)
   - 2.1 Time patient entered the operating room: __ __ : __ __ (hr : min)
   - 2.2 Time in which the first open or laparoscopic incision was made: __ __ : __ __ (hr : min)
   - 2.3 Time in which the final skin closure was made: __ __ : __ __ (hr : min)
   - 2.4 Time in which the patient left the operating room: __ __ : __ __ (hr : min)

3. Is this procedure a revision? ☐ 0. No ☐ 1. Yes

4. Is this procedure a reversal? ☐ 0. No ☐ 1. Yes

5. Procedure performed:
   - ☐ 1. None (Surgery cancelled after anesthesia induction) → ***Do not complete the remainder of this form***.
   - ☐ 2. Gastric bypass
     - Specify: ☐ 1. Proximal (Roux length < 250 cm) → (Roux Length: ___ ___ ___ cm)
     - ☐ 2. Distal (Roux length ≥ 250 cm) → (Common Channel Length: ___ ___ ___ cm)
   - ☐ 3. Biliopancreatic diversion (BPD)
   - ☐ 4. Biliopancreatic diversion with Duodenal Switch (BPDS)

   5.1 Was the stomach divided? ☐ 0. No ☐ 1. Yes

   5.2 How was the Gastrojejunostomy / Duodenal-jejunostomy done?

No	Yes	
☐	☐	a. Hand sewn
☐	☐	b. Linear stapled
☐	☐	c. Circular stapled (EEA)

   5.3 Was the Gastrojejunostomy / Duodenal-jejunostomy reinforced/sealed? ☐ 0. No ☐ 1. Yes

   5.3.1 If yes, specify how:

No	Yes		No	Yes	
☐	☐	a. Sutures	☐	☐	d. Banding (ring, fascia, mesh, siliastic)
☐	☐	b. Omental Buttress	☐	☐	e. Other
☐	☐	c. Fibrin glue			(Specify: _____)

   - ☐ 5. Adjustable band → Specify length: ☐ 9.75 cm ☐ 10 cm ☐ 11 cm (or Vanguard) ☐ Other (specify: _____ cm)
   - ☐ 6. Sleeve gastrectomy – initial stage
   - ☐ 7. Sleeve gastrectomy – 2nd stage → ***Complete items 5.1, 5.2, 5.3 and 5.3.1 (if applicable)***
     - ☐ 1. Gastric bypass →
     - ☐ 2. BPD
     - ☐ 3. BPDS

     If Gastric Bypass, specify:
     - ☐ 1. Proximal (Roux length < 250 cm) → (Roux Length: __ __ __ cm)
     - ☐ 2. Distal (Roux length ≥ 250 cm) → (Com. Chan. Length: __ __ __ cm)
   - ☐ 8. Vertical Banded Gastroplasty
   - ☐ 9. Other (Specify: _____)
   - ☐10. Banded gastric bypass (Gastric bypass + non-adjustable band)

6. Was a resident or trainee present? ☐ 0. No ☐ 1. Yes

7. Method of Surgical Procedure:

□ 1. Laparoscopic: →

# of ports/incisions for each width (*enter '0' if none*):	5 mm	10-12 mm	15 mm
	# ____	# ____	# ____

□ 2. Laparoscopic converted to open: →

a. # of ports/incisions for each width (*enter '0' if none*):	5 mm	10-12 mm	15 mm
	# ____	# ____	# ____

b. Specify reason for conversion:

No	Yes		No	Yes	
□	□	a. Exposure	□	□	d. Instrument/equipment failure
□	□	b. Bleeding	□	□	e. Other (Specify: _____)
□	□	c. Anatomy			

c. Length of open incision (cm): __ __ __ . __

□ 3. Open (no laparoscopic ports): → (Length of incision (cm): __ __ __ . __)

8. Were any concurrent procedures performed? □ 0. No □ 1. Yes

8.1 If yes, check "no" or "yes" to each item in the box:

No	Yes		No	Yes		No	Yes	
□	□	a. Liver biopsy □ 0. Right lobe □ 1. Left lobe	□	□	f. Crural repair	□	□	k. Panniculectomy
□	□	b. Drain placed at gastrojejunostomy	□	□	g. Gastrectomy → □ 1. Partial □ 2. Subtotal	□	□	l. Planned fiberoptic intubation
□	□	c. Gastrostomy	□	□	h. Cholecystectomy	□	□	m. Incisional hernia
□	□	d. Unplanned splenectomy	□	□	i. Diagnostic EGD/EGJ: *NOTE: This item should NOT be checked if it was only used to check the integrity of the anastomosis.*	□	□	n. Lysis of extensive adhesions
□	□	e. Umbilical hernia	□	□	j. Vagotomy → □ 1. Truncal type □ 2. Partial type	□	□	o. Other (specify: _____)

9. Was a method used to test anastomosis? □ 0. No □ 1. Yes □ -2. N/A (band)

9. 1 If yes, check "no" or "yes" to each item in the box:

No	Yes		Results 1. Neg.	Results 2. Pos.	*If any of the tests were positive, was an action taken?*	No	Yes	Action *check "no" or "yes" for each item.*
□	□	a. Air by Tube →	□	□		□	□	Suture repair
□	□	b. Air by Endoscopy * →	□	□	□ 0. No □ 1. Yes →	□	□	Glue
□	□	c. Methylene Blue →	□	□		□	□	Complete anastomosis redo

***** *NOTE: Air by Endoscopy should only be checked if it was used to test the integrity of the anastomosis*

10. Were any DVT prophylaxis administered (pre-operative or intra-operative) or ordered (post-operative)? □ 0. No □ 1. Yes

10.1 If yes, check "no" or "yes" to each item in the box:

No	Yes		Pre-Operative Administration Timing: None (0)	1 - 2 hours (1)	Within 1 hour (2)	Within 30 minutes (3)	> 2 hours (4)	Intra-Operative Administration: No (0)	Yes (1)	Post-operatively Ordered: No (0)	Yes (1)
□	□	a. Compression stockings									
□	□	b. Sequential compression device									
□	□	c. Prophylactic vena cava filter									
□	□	d. Foot pump									
□	□	e. 5000 units sub-cutaneous heparin →	□	□	□	□	□	□	□	□	□
□	□	f. Other dose heparin (Dose: ___ units) →	□	□	□	□	□	□	□	□	□
□	□	g. Low molecular weight heparin →	□	□	□	□	□	□	□	□	□
		If low molecular weight heparin: □ 20 mg □ 40 mg □ 60 mg □ Other (specify: _____ mg)									
□	□	h. Other Anticoagulant →	□	□	□	□	□	□	□	□	□
		Name: _____ Dose _____ Specify whether mg or unit: □ 1. mg □ 2. unit									

11. Record fluids and blood loss during surgery: Crystalloid fluids: __ __ __ (ml) Blood loss: __ __ __ (cc) *(if < 50 cc, enter "0")*

Colloid fluids: __ __ __ (ml) Blood transfusion: __ __ __ (units)

12. Anesthesia risk-derived classification: □ 1. Stage I □ 2. Stage II □ 3. Stage III □ 4. Stage IV

13. Were there any intra-operative events? □ 0. No □ 1. Yes

13.1 If yes, check "no" or "yes" to each item in the box:

No	Yes	
□	□	a. Instrument/equipment failure
□	□	b. Revision of anastomosis (if yes)
		No Yes
		□ □ Gastrojejunostomy
		□ □ Jejunostomy
		□ □ Other (Specify: _____)
□	□	c. Organ injury requiring suture/other repair (if yes)
		No Yes — I II III IV V
		□ □ Spleen→ Grade: □ □ □ □ □
		□ □ Liver
		□ □ Bowel
		□ □ Named Blood Vessel
		□ □ Other (Specify: _____)
□	□	d. Subcutaneous emphysema
□	□	e. Intra-operative transfusion
□	□	f. Anesthesia event(s) (if yes)
		No Yes
		□ □ Witnessed aspiration
		□ □ Surgical airway required
		□ □ Multiple intubation attempts or unplanned fiber optic intubation
		□ □ Cardiac ischemia
		□ □ Sustained dysrhythmia
		□ □ Sustained hypoxia
		□ □ Sustained hypotension
		□ □ Sustained hypercarbia
□	□	g. Other event that required an unexpected course of action. (Specify: _____)

14. Lowest reported or known body temperature: __ __. __ (C^o) → 14.1 Specify temperature source: □ 1. Skin (including cartilage) □ 2. Core

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

For office use only.

Post -Operative Evaluation Form (POST1) – Version: 08/28/2006

Patient ID __ __ __ - __ __ __ __ - __ __ **Form Completion Date** __ __ / __ __ / 20 __ __
mm dd yy

Certification number: ___ ___ ___ ___ ___ **Date of Surgery** __ __ / __ __ / 20 __ __
mm dd yy

Date of most recent contact:

1. Source(*s*) of Information: (*check all that apply*)
   - ☐ Patient in Person __ __ / __ __ / 20 __ __
   - ☐ Patient by Telephone __ __ / __ __ / 20 __ __
   - ☐ Patient Representative __ __ / __ __ / 20 __ __
   - ☐ Other Physician __ __ / __ __ / 20 __ __
   - ☐ Chart Review __ __ / __ __ / 20 __ __

2. Length of hospital stay for obesity surgery: _____ (days)

3. Discharge location:
   - ☐ 1. Home
   - ☐ 2. Rehabilitation facility
   - ☐ 3. Skilled nursing facility
   - ☐ 4. Other hospital
   - ☐ 5. Was not discharged

   3.1 Discharge Date: __ __ / __ __ / 20 __ __

4. Were the surgical wound edges opened within 30 days following surgery? ☐ 0. No ☐ 1. Yes

5. Did the wound edges separate within 30 days following surgery requiring packing or bandage? ☐ 0. No ☐ 1. Yes

6 Did the patient die? ☐ 0. No ☐ 1. Yes → Date of death: __ __ / __ __ / 2 0 __ __
mm dd yy

If No,

6.1 Status Date: __ __ / __ __ / 20 __ __ (Most recent date participant known to be alive)

7. Was the patient re-hospitalized after initial discharge? ☐ 0. No ☐ 1. Yes

If Yes,

7.1 # of times re-hospitalized: # ___ ___

7.2 Date of first re-hospitalization: __ __ / __ __ / 2 0 __ __
mm dd yy

7.3 Were any of these related to a cardiac event? ☐ 0. No ☐ 1. Yes

8. Did the patient have any post-bariatric surgical operations or undergo **unplanned** post-discharge anticoagulation therapy?
☐ 0. No ☐ 1. Yes

If yes, specify all of the bariatric surgical operations or anticoagulation therapies below:

No	Yes	Event	Date first performed after surgery (mm/dd/yy)	Suspected reason for intervention *(see codes on next page)*	Was the reason for the intervention confirmed? No	Yes
☐	☐	8.1 Abdominal re-operation				
		8.1.1. Specify approach: → ☐ 1. Laparoscopic ☐ 2 Laparoscopic converted to Open ☐ 3. Open				
		8.1.2. Specify procedure:				
☐	☐	a. Operative drain placement	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	b. Gastrostomy	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	c. Anastomotic revision				
		Specify revision: → ☐ GJ	__ __ / __ __ / 20 __ __	_____	☐	☐
		☐ JJ	__ __ / __ __ / 20 __ __	_____	☐	☐
		☐ DJ	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	d. Band replacement	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	e. Band/port revision	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	f. Wound revision or evisceration	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	g. Re-exploration	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	h. Other (Specify: _____)	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.2 Tracheal reintubation	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.3 Tracheostomy	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.4 Endoscopy	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.5 Placement of percutaneous drain	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.6 Anticoagulation therapy for presumed/confirmed DVT	n/a	n/a	☐	☐
☐	☐	8.7 Anticoagulation therapy for presumed/confirmed PE	n/a	n/a	☐	☐
☐	☐	8.8 Readmission (other) 1 (Specify: _____)	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.9 Readmission (other) 2 (Specify: _____)	__ __ / __ __ / 20 __ __	_____	☐	☐
☐	☐	8.10 Readmission (other) 3 (Specify: _____)	__ __ / __ __ / 20 __ __	_____	☐	☐

9. Were any post-discharge anticoagulation therapies <u>received</u>? 0. No 1. Yes

If yes,

No	Yes		Prophylactic (preventative) Use? No	Yes	# of Days	Times per day	Therapeutic (as treatment) Use? 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								

Table of codes for
suspected reason for an intervention

Code	Suspected reason for an intervention	Code	Suspected reason for an intervention
1	Anastomotic leak	9	Fluid or electrolyte depletion
2	Other abdominal sepsis	10	Vomiting or poor intake
3	Intestinal obstruction	11	Gastric distension
4	DVT	12	Strictures
5	Pulmonary embolism	13	Bleeding
6	Pneumonia	14	Infection/fever
7	Other respiratory failure	15	Other
8	Wound infection/evisceration		