

Entered: __/__/20__ mm dd yy	Initials: _____	Verified: __/__/20__ mm dd yy	Initials: _____
Patient ID _____ - _____ - _____			Visit: <u>1</u>
For office use only.			

PETSB – Version: 12/15/2006

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

1. Have you **ever been** admitted to a hospital (including partial hospitalization or day hospital treatment) for treatment of psychiatric or emotional problems?

0. No 1. Yes

*Skip to
question 2*

1.1 Total number of hospital admissions (including partial and day hospital) for treatment of psychiatric or emotional problems in your lifetime? _____ (if none, enter '0')

1.2 Number of inpatient (overnight) hospital admissions in the **past 12 months**? _____ (if none, enter '0')

1.3 Number of partial hospital/day hospital admissions in the **past 12 months**? _____ (if none, enter '0')

1.4 What was the **most recent** problems you were treated for in a hospital? (*check "no" or "yes" for each*)

No	Yes	No	Yes	No	Yes
<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>	Alcohol/drug abuse	<input type="checkbox"/> <input type="checkbox"/>	Other (_____)
<input type="checkbox"/> <input type="checkbox"/>	Anxiety	<input type="checkbox"/> <input type="checkbox"/>	Eating disorder		

1.5 Have you **ever** been treated for any other psychiatric or emotional problems in a hospital? 0.No 1.Yes

If yes,

1.5.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**? (*check "no" or "yes" for each*)

No	Yes	No	Yes	No	Yes
<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>	Alcohol/drug abuse	<input type="checkbox"/> <input type="checkbox"/>	Other (_____)
<input type="checkbox"/> <input type="checkbox"/>	Anxiety	<input type="checkbox"/> <input type="checkbox"/>	Eating disorder		

2. Other than within a hospital, in the **past 12 months** have you been treated by anyone such as a counselor or mental health professional for psychiatric or emotional problems?

0. No 1. Yes
 ↓ ↓

*Skip to
question 3*

2.1 What was the most recent problems you were seen for? (*check "no" or "yes" for each*)

No Yes	No Yes	No Yes
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> <input type="checkbox"/> Other (_____)
<input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> Eating disorder	

2.2 Were you treated for any other problems in the **past 12 months**? 0. No 1. Yes
 If yes,

2.2.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**?
 (*check "no" or "yes" for each*)

No Yes	No Yes	No Yes
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> <input type="checkbox"/> Other (_____)
<input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> Eating disorder	

2.3 Are you **currently** seeing anybody for psychiatric or emotional problems? 0. No 1. Yes

2.4 How often have you, during the **past 6 months**, seen a mental health counselor/ professional for psychiatric or emotional problems?

Never 1 to 5 times 6 to 10 times 11– 20 times more than 20 times

3. Have you **ever taken** any medications for psychiatric or emotional problems?

0. No 1. Yes
 ↓ ↓

*Skip to
question 4*

	Have you ever taken ...	Are you currently taking ...
Antidepressants (<i>i.e., Prozac, Zoloft, Paxil</i>)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes→	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
Major tranquilizers (<i>i.e., Risperdal, Zyprexa</i>)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes→	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
Minor tranquilizers (<i>i.e., Ativan, Xanax</i>)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes→	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
Mood stabilizers (<i>i.e., Lithobid, Tegretol, Topamax</i>)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes→	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

4. Did you have a mental health evaluation (includes evaluation by social worker) prior to being accepted for bariatric surgery?

0. No 1. Yes



Skip to question 5



<p>4.1 Were you told to seek counseling or other mental health care prior to surgery?</p> <p><input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p>↓ ↓</p> <p><i>Skip to question 5</i></p> <table border="1"><tr><td>4.1.1 Did you do so? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</td></tr><tr><td>4.1.2 How many sessions did you attend? _____ (If none, enter 0)</td></tr></table>	4.1.1 Did you do so? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	4.1.2 How many sessions did you attend? _____ (If none, enter 0)
4.1.1 Did you do so? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		
4.1.2 How many sessions did you attend? _____ (If none, enter 0)		

5. Did you have nutritional counseling by a dietician prior to surgery?

0. No 1. Yes



Skip to next page



5.1 How many sessions? _____ (If none, enter 0)

PSYCHIATRIC & EMOTIONAL TEST SURVEY (PETSb)

<p>PURPOSE:</p> <p>PERSON(S) RESPONSIBLE:</p> <p>SOURCES OF INFORMATION:</p> <p>WHEN TO ADMINISTER FORM:</p> <p>GENERAL INSTRUCTIONS (Patient)</p> <p>GENERAL INSTRUCTIONS: (Clinician)</p> <p>SCORING ALGORITHM:</p>	<p>To collect psychiatric and emotional health information on patients aged 18 years or older enrolled in LABS-1, who have provided informed consent for LABS-2, prior to bariatric surgery.</p> <p>Clinician/Coordinator Patient</p> <p>Once patient provides informed consent for LABS-2, prior to surgery. This form should be administered after the WPAI and prior to the IW</p> <p>This questionnaire should be completed at the baseline visit only. It can be sent to patient by mail for patient to complete at home and return to coordinator prior to bariatric surgery or it can be completed at the clinic visit. The coordinator or other study staff must review the document at patient’s clinic visit to ensure that all fields have been completed appropriately.</p> <p>This questionnaire is to be completed by the patient. If the patient is not able to complete the form without help, the coordinator or patient designee may read the questions and answers to the patient.</p> <p>Before the form is given/sent to the patient:</p> <ul style="list-style-type: none"> (1) Write the patient id on the form. Because this form is administered at baseline only the visit number has been preprinted on the form. <p>After patient completes survey:</p> <ul style="list-style-type: none"> (1) Review the form for any missing items. Follow-up with patient if necessary to record missing items, or to clarify responses. (2) Make sure that each item has a single response marked, unless directions state otherwise. (3) If the patient does not understand the question, a coordinator or patient designee may read the question to them. Do not answer the question. Indicate whether the response is unknown or if the patient refused to provide an answer. <p>N/A</p>
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DATA SECTION	COMPLETION INSTRUCTIONS
<p>PATIENT ID:</p> <p>VISIT:</p> <p>FORM COMPLETION DATE:</p> <p>ADMISSIONS FOR PSYCHIATRIC OR EMOTIONAL TREATMENT:</p>	<p>Record the patient's ID number. The ID number is assigned via the ID registration application of the MATRIX Web Data Management System (MATRIX). Instructions on using this application are included in the MATRIX Manual. The patient ID should be written on every page of the BDI prior to it being administered to the patient.</p> <p><i>NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.</i></p> <p>Because this form is administered at baseline only, the visit number has been pre-printed on the form.</p> <p>Patient records date of form completion (mm/dd/20yy)</p> <ol style="list-style-type: none"> 1. Patient answers "No" or "Yes" if they have <i>ever</i> been admitted to a hospital for treatment of psychiatric or emotional problems. They should include partial hospitalizations or day hospital treatments. <p><u>If patient selects "No":</u> They may skip to question 2.</p> <ol style="list-style-type: none"> 1.1 Patient records the number of hospital admissions for treatment of emotional problems. They should include partial hospitalizations or day hospital treatments and should consider all hospitalizations throughout their lifetime. 1.2 Patient records the number of inpatient hospital admissions that they have had in the <i>past 12 months</i>. Inpatient hospital admissions include overnight hospitalizations only. <p><u>If patient has not had any inpatient hospital admissions in the past 12 months they should record "0".</u></p> 1.3 Patient records the number of partial hospital/day hospital admissions that they have and in the <i>past 12 months</i>. <p><u>If patient has not had any partial hospital/day hospital admissions in the past 12 months they should record "0".</u></p>

DATA SECTION	COMPLETION INSTRUCTIONS
<p>TREATMENT OF PSYCHIATRIC OR EMOTIONAL PROBLEMS OUTSIDE OF A HOSPITAL:</p>	<p>1.4 Patient records the <u>most recent</u> problem that they were treated for in a hospital. Patient should include problems that resulted in partial hospital/day hospital admissions, as well as in-patient/overnight admissions. They must select “Yes” or “No” for each:</p> <ol style="list-style-type: none"> 1. Depression 2. Anxiety 3. Alcohol/drug abuse 4. Eating disorder 5. If patient has been treated for any other psychiatric or emotional problem <i>in the past 12 months</i> they should select “Yes” for Other, and provide that reason in the text field. <p>1.5 Patient records if they were treated for any other problems in a hospital. Note that the time frame should be based on if the patient “ever” has been treated. Patient should include problems that resulted in partial hospital/day hospital admissions, as well as in-patient/overnight admissions. If so, they must select “Yes” or “No” for each if occurred in the past 12 months:</p> <ol style="list-style-type: none"> 1. Depression 2. Anxiety 3. Alcohol/drug abuse 4. Eating disorder 5. If patient has been treated for any other psychiatric or emotional problem <i>in the past 12 months</i> they should select “Yes” for Other, and provide that reason in the text field. <p>2. Patient records “No” or “Yes” if they were treated by a counselor or mental health professional for psychiatric or emotional problems <u><i>other than hospital treatment</i></u> in the <i>past 12 months</i>.</p> <p><u>If patient selects “No”:</u> Patient may skip to question <u>3.</u></p>

DATA SECTION	COMPLETION INSTRUCTIONS
	<p>2.1 Patient records the <u>most recent</u> problem that they were treated for outside of a hospital. They must select “Yes” or “No” for each:</p> <ol style="list-style-type: none"> 1. Depression 2. Anxiety 3. Alcohol/drug abuse 4. Eating disorder 5. If patient has been treated for any other psychiatric or emotional problem <i>in the past 12 months</i> they should select “Yes” for Other, and provide that reason in the text field. <p>2.2 Other than those in section 2.1, patient records “Yes” or “No” if they were treated for any other problems in the <i>past 12 months</i>.</p> <p><u>If patient selects “No”:</u> Patient may skip to question <u>2.3</u>.</p> <p>2.2.1 Patient records the <u>other</u> psychiatric or emotional problems that they were treated for outside of a hospital <i>in the past 12 months</i>.. They must select “Yes” or “No” for each:</p> <ol style="list-style-type: none"> 1. Depression 2. Anxiety 3. Alcohol/drug abuse 4. Eating disorder 5. If patient has been treated for any other psychiatric or emotional problem <i>in the past 12 months</i> they should select “Yes” for Other, and provide that reason in the text field. <p>2.3 Patient selects “No” or “Yes” if the are <i>currently</i> being treated for psychiatric or emotional problems.</p> <p>2.4 Patient records number of times that they have seen a mental health counselor/professional for psychiatric or emotional problems <i>in the past 6 months</i>.</p>

DATA SECTION	COMPLETION INSTRUCTIONS
	<p>3. Patient records if they have <i>ever</i> taken any medications for psychiatric or emotional problems.</p> <p><u>If patient selects “No”:</u> Patient may skip to question 4.</p> <p><u>If patient selects “Yes”:</u> Patient must indicate if they have <i>ever</i> taken or are <i>currently</i> taking the following psychiatric or emotional medications:</p> <ul style="list-style-type: none"> • Antidepressants • Major Tranquilizers • Minor Tranquilizers • Mood Stabilizers <p>4. Patient records “No” or “Yes” if they have had a mental health evaluation prior to being accepted for bariatric surgery. This evaluation can include an interview by social worker.</p> <p><u>If patient selects “No”:</u> Patient may skip to question 5.</p>
	<p>4.1 Patient selects “No” or “Yes” if they were told to seek counseling or other mental health care prior to surgery.</p> <p><u>If patient selects “No”:</u> Patient may skip to question 5.</p> <p>4.1.1 Patient selects “No” or “Yes” if they attended recommended counseling.</p> <p>4.1.2 Patient indicates number of sessions attended. If patient did not attend any sessions they should write “0” in the text field provided.</p> <p>5. Patient selects “No” or “Yes” if they have had nutritional counseling by a dietician prior to surgery.</p> <p><u>If patient selects “No”:</u> Patient has completed the PETS.</p> <p>5.1 Patient records the number of sessions attended. If the patient did not attend any sessions, they should write “0” in the text field provided.</p>