

**SECTION A: ADMINISTRATIVE INFORMATION**

<b>A1. Registry ID #:</b> ___/___/_____	<b>A5. First contact with bariatric program:</b> ___/___/_____
<b>A2. Surgeon registry ID #:</b> ___/___/_____	<b>A6. Bariatric admission date:</b> ___/___/_____
<b>A3. Patient's initials:</b> _____	<b>A7. Bariatric procedure date:</b> ___/___/_____
<b>A4. Patient's date of birth:</b> ___/___/_____	

**SECTION B: PATIENT CHARACTERISTICS**

<b>B1. Gender</b> 1. <input type="checkbox"/> Male      2. <input type="checkbox"/> Female		<b>B4. Height</b> _____ 1. <input type="checkbox"/> cm 2. <input type="checkbox"/> inches		<b>B6a. Last recorded pre-op weight</b> _____ 1. <input type="checkbox"/> kg 2. <input type="checkbox"/> lbs	
<b>B2. Payer (Choose only one)</b> 1. <input type="checkbox"/> Medicaid      4. <input type="checkbox"/> Uninsured/Self-pay 2. <input type="checkbox"/> Medicare      5. <input type="checkbox"/> Other 3. <input type="checkbox"/> Private		<b>B5. Cigarette smoking</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes, past: ___pack yr(s) <input type="checkbox"/> Unknown pack year(s) Quit (Choose only one): 2a. <input type="checkbox"/> ___ Day(s) ago  2b. <input type="checkbox"/> ___ Month(s) ago  2c. <input type="checkbox"/> ___ Year(s) ago 2d. <input type="checkbox"/> Unknown quit time 3. <input type="checkbox"/> Yes, current: ___pack year(s) <input type="checkbox"/> Unknown pack year(s)		<b>B6b. Date weight recorded</b> ___/___/_____	
<b>B3. Mobility aids</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Cane/walker/ crutches 3. <input type="checkbox"/> Wheel chair/ scooter 4. <input type="checkbox"/> Bed-bound 5. <input type="checkbox"/> Mobility limited/ unknown aid type				<b>B6c. Weight at bariatric program start</b> _____ 1. <input type="checkbox"/> kg 2. <input type="checkbox"/> lbs	

**SECTION C: PRE-OPERATIVE MEDICAL CONDITIONS**

<b>C1. Lung disease</b> 1. <input type="checkbox"/> No/unknown <u>Check all that apply:</u> 2. <input type="checkbox"/> Asthma 3. <input type="checkbox"/> Other obstructive/restrictive lung disease 4. <input type="checkbox"/> Home oxygen use		<b>C7. Urinary incontinence</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes	
<b>C2. Cardiovascular disease</b> 1. <input type="checkbox"/> No/unknown <u>Check all that apply:</u> 2. <input type="checkbox"/> Echocardiogram 2a. <input type="checkbox"/> Ejection fraction (EF) ___% 2b. <input type="checkbox"/> Unknown EF 3. <input type="checkbox"/> Coronary artery disease (CAD) 3a. <input type="checkbox"/> Cardiac stress test 3a1. Reversible ischemia 3ai. <input type="checkbox"/> No 3aii. <input type="checkbox"/> Yes 3b. <input type="checkbox"/> Angina 3c. <input type="checkbox"/> Myocardial infarction (MI) 3d. <input type="checkbox"/> Percutaneous coronary intervention (PCI) 3e. <input type="checkbox"/> Coronary revascularization 4. <input type="checkbox"/> Heart rhythm disorder 5. <input type="checkbox"/> Congestive heart failure (CHF) 6. <input type="checkbox"/> Peripheral vascular disease (PVD) 7. <input type="checkbox"/> Treated hypertension (HTN), # meds: _____		<b>C8. Renal function</b> C8a. Creatinine (last pre-operative value) 1. <input type="checkbox"/> Unknown 2. Last pre-op Creatinine: _____ <input type="checkbox"/> mg/dL or <input type="checkbox"/> mmol/L C8b. Chronic renal failure 1. <input type="checkbox"/> No/unknown <u>Check all that apply:</u> 2. <input type="checkbox"/> Yes, on dialysis 2a. <input type="checkbox"/> Hemo 2b. <input type="checkbox"/> Peritoneal 3. <input type="checkbox"/> Yes, status post kidney transplant	
<b>C3. Hyperlipidemia</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes		<b>C9. Diabetes</b> 1. <input type="checkbox"/> No/unknown <u>Check all that apply:</u> 2. <input type="checkbox"/> Type I 3. <input type="checkbox"/> Type II 3a. <input type="checkbox"/> Diet 3b. <input type="checkbox"/> Oral medications 3c. <input type="checkbox"/> Insulin-dependent 4. <input type="checkbox"/> Gestational 5. <input type="checkbox"/> Diabetic complications 5a. <input type="checkbox"/> Neuropathy 5b. <input type="checkbox"/> Retinopathy 5c. <input type="checkbox"/> Amputation(s) 5d. <input type="checkbox"/> Other, specify: _____ _____ 6. Last recorded Hemoglobin A1c value: _____ %	
<b>C4. Gastroesophageal reflux disease (GERD)</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes, treated with (check all that apply): 2a. <input type="checkbox"/> Meds and/or endoscopic procedure 2b. <input type="checkbox"/> Surgery 2c. <input type="checkbox"/> Unknown treatment type		<b>C10. Liver disorder</b> 1. <input type="checkbox"/> No/unknown <u>Check all that apply:</u> 2. <input type="checkbox"/> Non-alcoholic fatty liver 3. <input type="checkbox"/> Cirrhosis 3a. <input type="checkbox"/> Subclinical 3b. <input type="checkbox"/> Clinical 4. <input type="checkbox"/> Status post liver transplant	
<b>C5. Peptic ulcer disease (PUD)</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes		<b>C11. Venous thromboembolism (VTE)</b> 1. <input type="checkbox"/> No/unknown      2. <input type="checkbox"/> Yes	
<b>C6. Cholelithiasis</b> 1. <input type="checkbox"/> No/unknown <u>Check only one:</u> 2. <input type="checkbox"/> Yes 3. <input type="checkbox"/> Status post cholecystectomy			

ADMINISTRATIVE INFORMATION

Registry ID#: \_\_\_/\_\_\_

Patient's initials: \_\_\_

SECTION C: PRE-OPERATIVE MEDICAL CONDITIONS (CONTINUED)

C12. Sleep apnea

1.  No/unknown 2.  Yes, check all that apply:  
 2a.  CPAP or BiPAP  
 2b.  Other treatment, specify: \_\_\_\_\_  
 2c.  Unknown treatment  
 3.  Cor pulmonale

C13. Psychological

1.  No/unknown Check all that apply:  
 2.  Depression  
 2a.  Past 2b.  Present  
 3.  Anxiety  
 3a.  Past 3b.  Present  
 4.  Bi-polar  
 4a.  Past 4b.  Present  
 5.  Eating disorder  
 5a.  Past 5b.  Present  
 6.  Substance abuse  
 6a.  Past 6b.  Present  
 7.  Other, specify: \_\_\_\_\_  
 7a.  Past 7b.  Present

C14. Musculoskeletal disorder

1.  No/unknown 2.  Yes

C15. Prior upper abdominal wall hernia repair

1.  No/unknown 2.  Yes

C16. Prior bariatric surgery

1.  No/unknown Check all that apply: Date: \_\_\_\_\_  
 2a.  RYGB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2b.  LB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2c.  BPD \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2d.  BPD/DS \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2e.  VBG \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2f.  Sleeve gastrectomy \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2g.  Revision \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 2h.  Other, \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Specify: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SECTION D: PERI-OPERATIVE PROCESS DATA

D1. Venous thromboembolism (VTE) prophylaxis

1.  No/unknown Check all that apply:  
 2.  Compression stockings  
 3.  Subcutaneous heparin  
 3a.  Pre-operatively  
 3b.  Intra-operatively  
 3c.  Post-op, on POD(s): \_\_\_\_\_  
 4.  LMW heparin  
 4a.  Pre-operatively  
 4b.  Intra-operatively  
 4c.  Post-op, on POD(s): \_\_\_\_\_  
 4d.  Post-discharge, for \_\_\_\_\_ day(s)  
 5.  IVC filter placed pre-operatively  
 5a.  Temporary  
 5b.  Permanent  
 5c.  Unknown filter type

D2. Procedure performed (Choose only one)

1.  BPD  
 2.  BPD/DS  
 3.  Sleeve gastrectomy

D3. OR Procedure Time (Skin to skin)

- D3a. Incision time: \_\_\_\_\_ (military time)  Unknown  
 D3b. Closure time: \_\_\_\_\_ (military time)  Unknown

D4. Approach

1.  Unknown Choose only one:  
 2.  Open  
 3.  Laparoscopic

D5. Convert to open

1.  No/unknown 2.  Yes  
 or N/A

D6. Other surgical procedures performed

1.  No/unknown Check all that apply:  
 2.  Cholecystectomy  
 3.  Hiatal hernia repair  
 4.  Abdominal wall hernia repair  
 5.  Appendectomy  
 6.  Liver biopsy  
 7.  Other, specify:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

D7. Intra-operative abdominal drain placed

1.  No/unknown 2.  Yes

D8. Aborted Bariatric procedure

1.  No/unknown 2.  Yes, specify reason:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ADMINISTRATIVE INFORMATION

Registry ID#: \_\_\_/\_\_\_\_\_-\_\_\_\_\_

Patient's initials: \_\_\_\_\_

## SECTION E: 30-DAY/IN-HOSPITAL OUTCOMES

## Surgical Complications

## Other Medical Complications

**E1. Bowel obstruction**

1.  No/unknown    Check all that apply:  
 2.  Yes, on POD(s): \_\_\_\_\_  
 3.  Reoperation on POD(s) : \_\_\_\_\_

**E7. Venous Thromboembolism (VTE)**

1.  No/unknown    Check all that apply:  
 2.  DVT on POD(s): \_\_\_\_\_  
 3.  PE on POD(s): \_\_\_\_\_

**E2. Anastomotic problem**

1.  No/unknown    Check all that apply:  
 2.  Ulcer on POD(s): \_\_\_\_\_  
 3.  Stricture/stenosis on POD(s): \_\_\_\_\_  
     3a.  Treated w/dilatation on POD(s): \_\_\_\_\_  
     3b.  Treated w/reoperation on POD(s): \_\_\_\_\_

**E8. Cardiac**

1.  No/unknown    Check all that apply:  
 2.  MI on POD(s): \_\_\_\_\_  
 3.  Cardiac arrest on POD(s): \_\_\_\_\_

**E3. Abdominal abscess**

1.  No/unknown    2.  Yes, on POD(s): \_\_\_\_\_

**E9 Renal failure**

1.  No/unknown    Check only one:  
 2.  Yes, temporary (in-hospital only)  
 3.  Yes, dialysis post-discharge

**E4. Wound complication**

1.  No/unknown    Check all that apply:  
 2.  Infection on POD(s): \_\_\_\_\_  
     2a.  Treated w/ antibiotics only  
     2b.  Treated w/ antibiotics & wound opening  
     2c.  Unknown treatment type  
     2d.  Reoperation on POD(s): \_\_\_\_\_  
 3.  Dehiscence on POD(s): \_\_\_\_\_  
     3a.  Treated with reoperation  
         on POD(s): \_\_\_\_\_

**E10. Respiratory**

1.  No/unknown    Check all that apply:  
 2.  Pneumonia on POD(s): \_\_\_\_\_  
 3.  Total time on ventilator:  
     3a.  < 48 hours  
     3b.  48 hours – 7 days  
     3c.  > 7 days  
 4. Reintubation:  
     4a.  No  
     4b.  Yes, on POD(s): \_\_\_\_\_  
 5.  Tracheostomy on POD(s): \_\_\_\_\_

**E5. Leak**

1.  No/unknown    Check all that apply:  
 2.  Percutaneous drain placed post-op  
     on POD(s): \_\_\_\_\_  
 3.  Reoperation on POD(s): \_\_\_\_\_  
 4.  Leak site  
     4a.  GJ  
     4b.  JJ  
     4c.  Stomach staple line  
     4d.  Duodeno-ileostomy  
     4e.  Jejunio-ileostomy  
     4f.  Other, specify: \_\_\_\_\_

**E11. Shock**

1.  No/unknown    2.  Yes, on POD(s): \_\_\_\_\_

**E12. Other complication(s)**

1.  No/unknown    Check all that apply:  
 2.  Yes, specify:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 on POD(s): \_\_\_\_\_  
 3.  Reoperation on POD(s): \_\_\_\_\_

**E6. Hemorrhage**

1.  No/unknown    Check all that apply:  
 2.  Intra/Post-op transfusion  
     Units of pRBCs: \_\_\_\_\_  
 3.  Reoperation on POD(s): \_\_\_\_\_  
 4.  Splenectomy on POD: \_\_\_\_\_

**ADMINISTRATIVE INFORMATION**

Registry ID#: \_\_\_/\_\_\_\_/\_\_\_\_

Patient's initials: \_\_\_ \_\_\_

**SECTION F: DISCHARGE DISPOSITION/READMISSIONS/VITAL STATUS**

**F1. Patient:** Check all that apply:

1.  Was discharged
  - a.  To **home** on (date): \_\_\_/\_\_\_/\_\_\_
  - b.  To **another facility** on (date): \_\_\_/\_\_\_/\_\_\_
2.  Was readmitted
  - a.  To **this** hospital from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_
  - b.  To **another** hospital for the treatment of (specify E1-E13): \_\_\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_  
 from (date): \_\_\_/\_\_\_/\_\_\_ to (date): \_\_\_/\_\_\_/\_\_\_
3.  Had an outpatient procedure on (date): \_\_\_/\_\_\_/\_\_\_ ; Procedure: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; Procedure: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; Procedure: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; Procedure: \_\_\_\_\_
4.  Was seen in the ED on (date): \_\_\_/\_\_\_/\_\_\_ ; For: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; For: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; For: \_\_\_\_\_  
 on (date): \_\_\_/\_\_\_/\_\_\_ ; For: \_\_\_\_\_
5.  Died; **Please immediately notify Andrea Osborne 734-998-7480; aosborne@umich.edu**
  - a.  In **this** hospital on (date): \_\_\_/\_\_\_/\_\_\_
  - b.  At **another** hospital on (date): \_\_\_/\_\_\_/\_\_\_
  - c.  At **home** on (date): \_\_\_/\_\_\_/\_\_\_

Person completing form (Please print): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_