Dr John Jorgensen

Upper GI & Bariatric Surgeon, Hernia repair, Laparoscopy, Gastroscopy and Colonoscopy

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| Dr Jorgensen’s bariatric program |

Our bariatric program is a comprehensive approach to weight loss, combining an integrated health approach with surgery, nursing, psychology, and nutritional guidance to improve your overall health.

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| **Follow ups with Dr Jorgensen, Practice Nurse, and Dietitian** |

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| **Appointment schedules** | **Treatment plan and expected outcomes** |
| Pre-operative plan + dietitian review | **Fasting plan:**  2+ weeks pending on your liver markers   * Review of weight related comorbidities * Fluid adequacy * Nutrition adequacy * Multivitamin supplementation |
| Week 3 post-op | **Post-op check-in**:   * Fluid adequacy * Nutrition adequacy * Multivitamin supplementation + compliance * Texture progression:   **Week 1: full fluid diet**  **Week 2 and 3: puree diet**  **Week 3-8: soft diet** |
| 3 months post-operatively | **Full assessment long-term goals:**   * Fluid adequacy * Nutrition adequacy * Multivitamin supplementation + compliance * Macronutrient education and guidance |
| 6 -24 months post-operatively with Dr Jorgensen, Practice Nurse, Dietitian | **Full assessment long-term goals:**   * Anthropometric measurements * Full blood screening at 6, 12, 18, 24 months * Assessment * Long-term goals * weight loss and weight maintenance |

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| **Personal information** |

**Mr/Mrs/Ms/Miss/Dr/Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GIVEN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PREFERRED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_POSTCODE: \_\_\_\_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICARE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REF # \_\_\_\_\_EXPIRY DATE: \_\_\_/\_\_\_/\_\_\_\_**

**HEALTH INSURANCE FUND: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEMBERSHIP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REF #\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF NEXT OF KIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO YOU:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRING DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you first hear about us?**

**☐ Website ☐ GP ☐ Media ☐ Hospital ☐ Friend ☐ Others**

**(specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_**

**PRIVATE SECTOR AMENDMENT ACT 2000**

**I give permission for Dr John Jorgensen to collect information from other medical practitioners and health providers**

**regarding my medical history, if required and to the release of information to other health providers, as necessary.**

**Pre-op assessment:**

**Date\_\_\_/\_\_\_/\_\_\_\_\_**

**Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB\_\_\_\_/\_\_\_/\_\_\_Age \_\_\_\_\_Sex Male\_\_\_\_\_ Female \_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_**

**Anthropometric measurements**:

|  |  |
| --- | --- |
| **Height** |  |
| **Weight** |  |
| **BMI** |  |

**Weight history:**

How old were you when you first became more than (9 kg) overweight? \_\_\_\_\_\_\_\_

Were you overweight as a child? **YES** or **NO**.

What was the highest weight you have been in your life? \_\_\_\_\_ kg

Have any of your close relatives been overweight or have/had obesity?

Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ (check all that apply)

**Weight treatment history:**

Have you ever been treated by a doctor for your weight **YES** or **NO**.

When (year)\_\_\_\_\_\_

How much weight did you lose? \_\_\_\_Kg

Have you ever seen a registered dietitian or a nutritionist? **YES** or **NO.**

Have you ever participated in a weight loss program? **YES** or **NO**

|  |  |  |  |
| --- | --- | --- | --- |
| **Diet programs**  E.g.: weight watchers | **Length of time** | **Weight lost** | **When?** |
|  |  |  |  |
|  |  |  |  |

**Have you ever taken medication to lose weight?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Was it effective?**  **How many Kg did you lose?** | **Did you have side effects that made you stop it?** | **How long did you take it?** |
|  |  |  |  |
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**Feelings About Eating and General Mood:**

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than you would normally have)? **YES** or **NO**

If yes, can you reflect on the reason why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever make yourself vomit to control your weight? **YES** or **NO**

Have you ever been diagnosed with (check all that apply)?

Binge eating disorder **YES** or **NO**,

Anorexia nervosa **YES** or **NO**

Bulimia **YES** or **NO**

Do you feel distressed about episodes of overeating? **YES** or **NO.**

Do you often feel like you have no control over your eating or that you are unable to **STOP** when satisfied? **YES** or **NO**.

Are you often embarrassed by how much you eat? **YES** or **NO.**

Do you feel guilty for overeating? **YES** or **NO**.

**Physical Activity**

Do you exercise regularly? **YES** or **NO**.

If “yes,” what kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary habits:**

**Religious restrictions on diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vegan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vegetarian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe your most common habits for each category! Please Circle**

|  |  |  |
| --- | --- | --- |
| **Meal/Snack** |  | **Please provide details/food choices** |
| Breakfast | **Y/N** |  |
| Morning snack | **Y/N** |  |
| Lunch | **Y/N** |  |
| Afternoon snack | **Y/N** |  |
| Dinner | **Y/N** |  |
| Evening snack | **Y/N** |  |
| Late night snack | **Y/N** |  |
| Grazing (eating small amounts frequently) | **Y/N** |  |
| Alcohol | **Y/N** |  |
| Water/soft drinks | **Y/N** |  |

**Food choices please select what you enjoy eating: Please circle which ones apply.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Proteins** | | **Veggies** | **Fruits** | **Fats** | **Carbohydrates** |
| **Meat:**  Ground beef  Steak  Beef  Pork  Lamb  Chicken  Turkey  Duck  **Fish:**  Salmon  Tuna  Cod  Trout  All other varieties  Canned meats:  Tuna  Salmon  Chicken  Ham  Crab | **Seafood:**  Scallops  Shrimp  Crab  Mussels  Lobster  Octopus  Oysters  Squid  **Eggs**  **Plant-based**  Tofu  Tempeh  Natto  Black Soybeans  Lentils  Kidney beans  Pinto beans  Edamame  Green peas | Asparagus  Bok Choy  Broccoli  Brussels sprouts  Cabbage  Cauliflower  Celery  Cucumber  Eggplant  Fennel  Green beans  Leeks  Lettuce  Mushrooms  Okra  Peppers  Pumpkin  Radishes  Shallots  Snow Peas  Spinach  Sprouts  Squash  Tomatoes  Turnips  Zucchini | Apple  Orange  Grapes  Banana  Strawberries  Blueberries  Pears  Watermelon  Cherries  Pineapple  Mango  Kiwi  Pomegranate  Avocado  Lemon  Lime  Figs  Cantaloupe  Custard apple  Dragon fruit  Plum  Coconut  Apricot  Other varieties: | **Nut oils:**  Olive  Coconut  Avocado  Sesame  Hazelnut  Macadamia nut  Walnut  Almond  **Dairy and cheeses:**  Milk (whole, skim, goats, sheep’s, lactose free)  Butter  Cream  Sour cream  Heavy cream  Greek yogurt  Yogurt high protein  Kefir  Ricotta  Cottage cheese  Other cheese varieties  Ice-cream  Gelato  Frozen yogurt | Rice  Bread  Pasta  Oats  Quinoa  Barley  Corn  Cereal (oat-based, bran, cornflakes)  **Starchy vegetables:**  Potatoes  Yams  Butternut squash  Corn  Pumpkin  Cassava  Taro root  Carrots  Turnips  Artichoke  Green bananas  Beets  Parsnips |

**Any foods you will not eat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical history:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reflux** | Y | N | Medication: |
| **Sleep apnea** | Y | N | Medication: |
| **Hypertension** | Y | N | Medication: |
| **High cholesterol** | Y | N | Medication: |
| **Diabetes** | Y | N | Medication: |
| **Insulin resistance** | Y | N | Medication: |
| **Polycystic ovary** | Y | N | Medication: |
| **Kidney disease** | Y | N | Medication: |
| **Heart disease** | Y | N | Medication: |
| **Gallbladder disease** | Y | N | Medication: |
| **Osteoarthritis** | Y | N | Medication: |
| **Cancer** | Y | N | Medication: |
| **Other** | Y | N | Medication: |

**Any other regular medications, including over the counter medications:**

|  |  |
| --- | --- |
| **Medication** | **Dosage** |
|  |  |
|  |  |
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**PRIVATE POLICY: This practice conforms to the requirements of the current Federal Privacy Legislation. A copy of our privacy policy is available on request. A record of your consultation and examination will be made and retained as part of this process.**

**I consent to the taking of photographs before and after surgery and understand they are not to be used for any purpose other than to keep track of my weight loss journey in Dr John Jorgensen’s practice.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:** \_\_/\_\_/\_\_

**Social Support:**

Does your family support your efforts to have a healthier lifestyle? **YES or NO**.

Do you see a counselor of any kind (e.g., therapist, religious leader, addiction counselor, psychologist, psychiatrist)? **YES or NO** If yes provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? **YES or NO**, if yes how many cigarettes/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you vape? **YES or NO**

Do you do recreational drugs? **Yes or No**

Do you drink alcohol? **YES or NO**, if yes how many drinks per/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery:**

Have you ever had bariatric surgery? **YES or NO.**

If **YES** what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently interested and considering bariatric surgery? **YES or NO**.

Have you ever consulted a surgeon regarding bariatric surgery? **YES or NO**.

Do you know anyone who had bariatric surgery? **Yes or NO**.

**Appointment checklist:**

|  |  |
| --- | --- |
|  | **Do you have a GP or Doctor’s referral** |
|  | **Have you done your blood test** |
|  | **Have you filled all forms before your appointment.** |

**Resources and additional information can be found here:** [WWW.drjohnjorgensen.com.au](http://WWW.drjohnjorgensen.com.au)

<Http://asmbs.org/>

[www.daa.asn.au](http://www.daa.asn.au)

<https://www.monash.edu/medicine/translational/research/registries/bariatric/reports-publications>

<https://thesmhp.org/clinical-guidelines/>