

## Bariatric Surgery Procedure Questionnaire – Renewal

**THIS QUESTIONNAIRE IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS QUESTIONNAIRE.**

Applicant Name: \_\_\_\_\_

Expiring Policy Number: \_\_\_\_\_

1. Which of the following procedures do you perform?

			# in Past 12 Mos	# in Next 12 Mos			# in Past 12 Mos	# in Next 12 Mos
	Laparoscopic				Open			
Roux en Y	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Banding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Other (describe): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____

2. If you have completed any additional training this past year for bariatric surgery, please include the details of your training and certification:

3. Have you had any post-operative deaths this past year?  Yes  No  
If "Yes," provide date and cause of death.

4. Have you had any post-operative complications requiring surgical repair this past year?  Yes  No  
If "Yes," indicate number and variety.

5. What percent of your practice includes bariatric surgery? \_\_\_\_\_ %

6. What percent of your bariatric surgeries are performed on persons under the age of 18? \_\_\_\_\_ %

7. Is the facility where you perform bariatric surgery equipped to accommodate larger patients (e.g. MRI, wheelchairs, furniture, and transfer equipment)?  Yes  No

8. In the past year, have you:

- changed your established systems for pre-operative and post-operative care (including long-term patient follow up)?  Yes  No
- changed your patient selection criteria (including minimum, maximum and average BMI)?  Yes  No
- changed your informed consent for bariatric procedures?  Yes  No

If "Yes," please provide details below.

**Notice:** Providing the above information in order to facilitate the renewal of your policy does not constitute the reporting of a "claim." Please refer to your policy for the appropriate means to report a "claim."

**SIGNATURE AND AUTHORIZATION**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this questionnaire are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this questionnaire.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	