

Sleeve Gastrectomy Test

Name: _____

Please complete the following examination, answering each question carefully. Your answers will help us to be certain that you fully understand the information which has been provided to you about your operation and also to point out to us what needs must be clarified and explained to you further.

Each statement is true or false. Please check the answer that you believe is correct:

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|------|-------|--|
| True | False | 1. It is important to eat high protein foods at the beginning of every meal such as eggs, cheese, fish and chicken following the SLEEVE GASTRECTOMY. |
| True | False | 2. There are no other operations or programs for obesity available, except the SLEEVE GASTRECTOMY. |
| True | False | 3. Staple lines may leak and may result in infection or an opening between the stomach and the skin. |
| True | False | 4. Clots may form in the legs or pelvis, which can break off and float into the lungs. These can cause breathlessness or chest pain, and can be fatal. |
| True | False | 5. It is important to exercise regularly after the SLEEVE GASTRECTOMY. |
| True | False | 6. Snacking throughout the day will improve my weight loss success after surgery. |
| True | False | 7. After the SLEEVE GASTRECTOMY, patients are guaranteed to permanently lose weight. |
| True | False | 8. Behavioral modification techniques (lifestyle changes) are important only for the first 6-12 months following weight loss surgery. |
| True | False | 9. Diabetes, high blood pressure, back pain, and similar ailments always get better after obesity surgery. |
| True | False | 10. When serious complications occur, intensive care for short or long term may be necessary. |
| True | False | 11. Re-operation may be necessary due to bleeding, hernias, ulceration, obstruction, stricture, bursting of staples, leakage or other causes. |
| True | False | 12. The SLEEVE GASTRECTOMY is a cure for obesity and afterwards patients can lead a normal life without regular medical care. |
| True | False | 13. After obesity surgery, the patient is committed to taking vitamin and mineral supplements; possibly including vitamin injections for life. |



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| True | False | 14. I am required to start a low calorie liquid protein diet before my surgery to help shrink my liver for optimal health and results. |
| True | False | 15. If a leak does occur, it may be difficult to manage, may require additional surgery or insertion of a stent, and may take weeks or months to completely heal. |
| True | False | 16. Obesity surgery is an easy operation and not a very serious or risky procedure. |
| True | False | 17. Patients do not usually feel nauseated or vomit immediately after the SLEEVE GASTRECTOMY. |
| True | False | 18. Complications only occur in the hospital. After discharge, medical problems are unlikely, so it is important not to bother the doctor with minor problems. |
| True | False | 19. It is important to avoid drinking fluids during meals and for 30 minutes following each meal to prevent early emptying of the stomach, which will decrease my fullness level. |
| True | False | 20. Patients can be quite uncomfortable or miserable for the first 48 hours after surgery. |
| True | False | 21. After a SLEEVE GASTRECTOMY, a person can eat as much of any kind of food as he/she wants and not gain weight. |
| True | False | 22. In the United States, approximately 8 out of 10,000 patients who have SLEEVE GASTRECTOMY SURGERY dies. |
| True | False | 23. After the SLEEVE GASTRECTOMY, significant nutritional problems may occur with protein, iron, vitamins, body salts, and minerals. |
| True | False | 24. A drain may be required after the SLEEVE GASTRECTOMY in order to measure contents draining from the abdominal cavity. |
| True | False | 25. It is important that I try to drink 64-ounces of fluid each day. Immediately following surgery I may not be able to drink that amount of fluid, but it is a goal to work toward each day to prevent dehydration. |

I certify that I took this test myself without any help in answering the questions. I also certify that the physician has reviewed the incorrect answers with me and I now have a clear understanding regarding those questions.

Patient Signature: _____ Date: _____

Incorrect answers were reviewed and clarified with patient.

Doctor: _____