Applicant's Name:	Completed by: (Name and Title)	Date:

BARIATRICS SUPPLEMENTAL APPLICATION

Date your facility began providing bariatric surgical services: _____

Type of Procedures	Number of Procedures	
1. Roux-en-Y (RYGB)	Open _____	Laparoscopic _____
2. Gastric Banding	Open _____	Laparoscopic _____
3. Vertical Band Gastroplasty (VBG)	Open _____	Laparoscopic _____
4. Biliopancreatic Diversion	Open _____	Laparoscopic _____
5. Other (please describe)	Open _____	Laparoscopic _____
6. Other (please describe)	Open _____	Laparoscopic _____

Credentials of Surgeons:

Please provide the following for each surgeon who performs bariatric surgery at your facility:
1. A copy of the surgeon's credentials;
2. Documentation of patient outcomes that you have monitored for the past year.

Patient Selection Criteria:

1. Do you do any pediatric/adolescent patients under 18 years? ☐ YES ☐ NO
2. After enrolling as a surgical candidate, how soon can a patient undergo surgery? _____Months
3. Please attach:
   a. Details on your Pre-op evaluation program;
   b. Details on your Patient Education program.
4. How many patients have been refused surgical intervention in the last year? (Please describe the most common reasons in the Comments Section.) _____

Facility Details:

1. Does your facility have imaging equipment designed for morbidly obese patients? (Please describe available equipment in the Comments Section.) ☐ YES ☐ NO
2. Does your staff include pulmonology, interventional radiology, and cardiology specialists? ☐ YES ☐ NO
3. Is your facility accredited by Surgical Review Corporation? ☐ YES ☐ NO
4. Who is called at night if there are any problems with the patient during the immediate post-operative period? _____

Comments Section:

_____

_____

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