Post Bariatric Surgery Pre-Determination Worksheet

Tummy Tuck, Brachioplasty, Thighplasty

The information you provide will help in the medical necessity letter that will be going to your insurance company.

Your insurance company, in most cases, requires medical records from providers (Doctors, Physical Therapy, Chiropractic Care, etc.) who have treated you for the symptoms listed below. It would be helpful to provide us with supporting documentation prior to your consultation.

Patient Name_____ **Current Weight** _____ **Height** _____

Check surgeries you are interested in
___Panniculectomy/Tummy Tuck ___Brachioplasty/Arm Lift ___Thighplasty/Thigh Lift

Surgeries you have had: ___Gastric Bypass ___Lap Band ___ Roux-en-y **Date of surgery:** _____

Have you lost weight on your own? _____ How much have you lost? _____ Have you reached your goal weight? _____

Has your weight been stabilized for the last 3 months? _____

Check mark Symptoms you are experiencing

___Hernia present
___Exercise Intolerance
___Poor Posture
___Back pain
___Infections, yeast
___Chafing
___Itching
___Redness
___Hygiene concerns
___Chronic rashes
___Mobility problems
___Cellulitis
___Ulcers

Conservative Treatment

___physical therapy
___chiropractic care
___pain medication
prescription or over the counter
___muscle relaxers
___support garments
___ointments
___powders
___creams
___heat/cold pack

Misc:

Name of clinician(s) that have treated these symptoms: _____

Medical Records Authorization: I authorize _____ to release my medical records to Florida Plastic & Reconstructive Surgery. This information will be used on my behalf for the purposes of continuity of care.

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____