



Center of  
Excellence  
BARIATRIC SURGERY

BLUEPOINT  
SURGICAL GROUP



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**INFORMED CONSENT FOR LAPAROSCOPIC ADJUSTABLE  
GASTRIC BAND PLACEMENT**

It is very important to the surgeons that you understand and consent to the treatment they are rendering and any procedure they may perform. You should be involved in any and all decisions concerning surgical procedures your surgeon has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of the paragraph.

Patient's Initials or Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed drawings of each of the available bariatric operations that diagrammatically show the main characteristics of each type of weight reduction operations, differences among operations, advantages, and disadvantages, of each procedure. I have had a chance to express to my surgeon my eating habits and behavior and my medical history and the surgeon has helped me to personally come to a conclusion as to the most appropriate operation for me, factoring in my eating, dietary, and medical background, and my future weight loss goals, pregnancy plans, and personal limits regarding acceptable meal size, bowel habits, and risk tolerance. My surgeon has counseled me regarding my decision, has made professional recommendations, and we have together agreed on the planned procedure as acceptable and appropriate.

Patient's Initials or Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize my surgeon and any associates or assistants the doctor deems appropriate, to perform laparoscopic gastric band surgery. The surgeon has explained to me the risks of obesity and the benefits of a gastric band procedure. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as deemed advisable or necessary for my comfort, well being and safety.

**Condition-** I recognize that I am severely overweight with a weight of \_\_\_\_\_ lbs. at \_\_\_\_\_ ft. \_\_\_\_\_ inches tall. The surgeon has clearly explained to me that this level of obesity has been shown to be unhealthy and that many scientific studies show that persons of this level of obesity are at increased risks of respiratory disease, high blood pressure, heart disease, high cholesterol, stroke, diabetes, arthritis, clotting problems, cancer and death as well as other serious and less serious medical illnesses.

Patient initials \_\_\_\_\_



**Commitment-** I am committed to long-term follow-up with my surgeon or surgeons and to make every effort to follow his/her directions to protect myself from these and other problems associated with gastric banding. I understand that to be effective, I need to make a life-long commitment to lifestyle changes, **which may include, but not be limited to:** dietary changes, an exercise program, and counseling. I understand that I will need to maintain proper nutrition, eat a balanced diet, and take vitamin and mineral supplements for the rest of my life. I will also be required to maintain follow-up medical care for my lifetime. Laboratory work will be required at least annually and perhaps more often, as directed by a physician.

**Pre-operative Requirements-** I have completed the Physician-Supervised Multidisciplinary Program, which included dietary therapy (a discussion of dietary history and a nutritional visit by either a physician or dietician and supervised dietary therapy), physical activity, behavior therapy and support groups. Since the time of my initial evaluation to the date of surgery, I have either maintained my weight or have lost weight.

**Post-operative Requirements-** I agree to participate in post-surgical follow-up visits at intervals of 1-2 months post-surgery for the first year, every 6 months for the second and third years, and annually for life thereafter with my surgeon or someone designated by my surgeon. I also agree to follow a multi-disciplinary program post-surgery as suggested by Bluepoint Surgical Group or other designated physician which may include diet, physical activity, and behavior modification.

**Proposed Procedure-** I understand that the procedure that my surgeon or surgeons have recommended for the treatment of my obesity is the gastric band procedure. My surgeon or surgeons have provided a detailed explanation of the proposed procedure. I have been strongly encouraged to make every effort to investigate and understand the details of the operation. I understand the nature of a gastric band procedure, which will be done laparoscopically. I understand that performing this procedure laparoscopically entails the use of a fiberoptic endoscope along with special endoscopic instruments and staplers to facilitate in completing the procedure with smaller incisions than in an open approach. I understand that it may be necessary to convert the procedure to an open technique if it is felt to be the best medical/surgical decision in the judgment of my surgeon (s). This conversion will result in a larger incision, which has been described to me by my surgeon.

**Risks/Possible Complications-** BluePoint Surgical Group has explained to me that there are risks and possible undesirable consequences associated with any surgery, as well as risks and possible undesirable consequences associated with the band procedure and these include, **but are not limited to:** blood loss, transfusion reactions, infection, heart complications, blood clots, loss of or loss of use of body part, other neurological injury, gastric perforation (a tear in the stomach wall) during or after the procedure that might lead to the need for another surgery; hospitalization and /or re-operation; nausea vomiting; gastro esophageal reflux (regurgitation); band slippage/pouch dilatation; stoma obstruction (stomach-band outlet blockage); esophageal dilatation or dysmotility (poor esophageal function) which can be caused by improper placement of the band, the band being tightened too much, stoma obstruction, binge eating, or excessive vomiting, constipation; dysphasia (difficulty swallowing); re-operation to fix a problem with the band or initial surgery or to fix a leak or twisted access port; band erosion into

Patient initials \_\_\_\_\_



the stomach; band removal in a second operation, esophagitis (inflammation of the esophagus), gastritis (inflammation of the stomach), hiatal hernia, incisional hernia, infection, redundant skin, dehydration, diarrhea (frequent semi-solid bowel movements), abnormal stools, constipation, flatulence (gas), dyspepsia (upset stomach), eructation (belching), cardio spasm (an obstruction of passage of food through the bottom of the esophagus), hematemesis (vomiting of blood), asthenia (fatigue), fever, chest pain, incision pain, contact dermatitis (rash), abnormal healing, edema (swelling), paresthesia (abnormal sensation of burning, prickly, or tingling), dysmenorrhea (difficult periods), hypo chromic anemia (low oxygen carrying part of blood), band system leak, cholecystitis (gall stones), esophageal ulcer (sore), port displacement, port site pain, spleen injury, wound infection, ulceration, gastro esophageal reflux (regurgitation), heartburn, gas bloat, dehydration, regaining of weight, slow weight loss or none at all, anemia, vitamin deficiencies and malnutrition, and/or death. I understand that if I need blood or blood products; these carry a risk of contracting HIV/AIDS, hepatitis, or other blood borne diseases. Laparoscopic surgery has its own potential risks and complications, which **include but are not limited to** spleen or liver damage (sometimes requiring spleen removal), damage to major blood vessels, lung problems, thrombosis (blood clots), rupture of the wound, and perforation of the stomach or esophagus during surgery. Risks and possible complications are also associated with the band procedure, **which include but are not limited to**, spontaneous band deflation due to leakage (which can come from the band, the reservoir, or the tubing that connects them), band slippage, stomach slippage, stomach pouch enlargement, stoma (stomach outlet) blockage (caused by food, swelling, improper placement of the band, over-inflation of the ban, band or stomach slippage, twisting of the stomach pouch, or stomach pouch enlargement), and erosion of the stomach.

Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I am expressly authorizing. I also understand that some or all of the complications listed on this form which have also been explained to me may exist regardless of whether the surgery is performed. Gastric band surgery is not the only cause of these complications. I understand that women of childbearing age should avoid pregnancy until their weight becomes stable because rapid weight loss and nutritional deficiencies can harm a developing fetus.

**Alternative Procedures.** In permitting the surgeon to perform this procedure, I understand that unforeseen conditions may necessitate change or extension of the original procedure(s), including completing the operation by way of the conventional open surgical approach, or a different procedure from what was explained to me. I therefore authorize and request that the above-named surgeon(s), his assistants or designees to perform such procedure(s) as may be necessary and desirable in the exercise of his/her professional judgment. The reasonable alternative(s) to the procedure(s), as well as the risks to the alternatives, have been explained to me. These alternatives include, **but are not limited to**, laparoscopic gastric bypass, vertical banded gastroplasty, duodenal switch, laparoscopic gastric sleeve, various diet exercise and drug treatments. I hereby authorize the disposal of removed tissues resulting from the procedure(s) authorized above. I consent to the photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive text accompanying them. I consent to the admittance of students and/or authorized

Patient initials \_\_\_\_\_



equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the surgeons all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

Date Time Signature of Patient or Authorized Representative

Relationship of Authorized Representative

- The Patient/Authorized Representative has read this form or had it read to him/her.
The Patient/Authorized Representative states that he/she understands this information.
The Patient/Authorized Representative has no further questions.

Date Time

Signature of Witness

CERTIFICATION OF PHYSICIAN:

I hereby certify that I, expressed above as "surgeon" have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Date Time

Signature of Physician

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

- Foreign language (specify)
Sign language
Patient is blind, form read to patient
Other (specify)

Interpretation provided by:

(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance) Date Time

Patient initials