HOUSTON surgical specialists

Endoscopic Sleeve Gastroplasty Surgery Consent Forms Out-of-Town Patients

Dr. Robert G. Marvin
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POST – OPERATIVE PROBLEMS AFTER SURGERY

Early Problems the first 1-10 days after surgery: In general, the first week after surgery is an important period to monitor for problems, as the majority of complications will occur during this time. If you notice signs or symptoms of the following, please notify the office immediately by calling **713-993-7124**.

- Persistent Vomiting
- Stenosis
- Stomach Obstruction
- Passing Blood
- Chest Pain
- Fever (could indicate sepsis/infection)
- Shortness of Breath (could indicate blood clot; look for swollen legs or one larger then the other).

POST -OPERATIVE FOLLOW-UP APPOINTMENTS

- Monday – Post- op visit with Dr. Marvin in his office following surgery.
- 3 Months
- 6 Months
- 1 year
- Annually

If you are experiencing any problems, please schedule an appointment at any time in-between planned follow up visits by calling our office at 713-993-7124.

In the event that your follow-up care is being provided by a physician other than your surgeon (if you live in another city or state), the following lab work should be complete during designated follow-up office visits: CBC, SMA7, PTH level, ionized calcium, serum iron binding capacity, iron saturation, B12, folate, B1-whole blood, and ferritin.

Patient's Name: _____ Date: _____

Patient's Signature: _____

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SURGERY RISK

STATE LAW REQUIRES THATYOU BE INFORMED ABOUT YOUR ONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY ACTIVELY PARTICIPATE IN THE DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISK AND HAZARDS INVOLVED THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU, BUT IS SIMPLY AN EFFORT TO MAKE YOU BETTER INFORMED SO YOU MAY PARTICIPATE IN THE DECISION OR WITHHOLD YOUR CONSENT TO THE PROCEDURE.

CONSENT

I voluntarily request **Dr. Robert Marvin**, as my physician, associates and technical assistants as he may deem necessary, to treat my condition which has been explained to me as: EXOGENOUS MORBID OBESITY.

I understand that the following surgical, medical and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: **Endoscopic Sleeve Gastroplasty** procedure to reduce food intake, and if required, Radiology, EKG, and/or multiple blood tests. If medically necessary, I consent a pathology performance is done at the time of my procedure, and understand I will be responsible for any obligation for this procedure if my insurance does not cover it.

The risk of such surgical and other procedures have been explained to me. I also understand that if a condition is found present that warrants cancellation of the surgery per my surgeon, the surgical procedure will not be performed as stated.

I understand that my physician may discover other or different conditions, which may require additional or different procedures than those planned. I authorize my physician, and his associates and technical assistants to perform such other procedure, which are advisable in their professional judgement. I (do, do not) consent to use of blood and blood products as deemed necessary. I do consent to the administration of anesthesia, and the performance of pathology and radiology services at additional cost.

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I understand that no warranty or guarantee has been made to me as to result and cure. There is no guarantee or assurance that desirable weight loss will be maintained, no guarantee or assurance that the suture line will not become disrupted thus causing a greater capacity for food tolerated.

Just as these are risk and hazard in continuing my present medical condition uncorrected, there are also risks and hazards attendant to the performance of the surgical, medical, and/or diagnostic procedures, the potential for infections, stenosis, stomach obstruction, blood clots in vein, stomach leak and/or death.

I have been given an opportunity to ask questions about my condition and the associated risks, the procedures used and the risks and hazards involved. Alternative forms of treatment such as dieting, diet medications and other weight loss surgical procedures have been explained to me, as well as the risks of non-treatment. I believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I am _____ years of age, that I attended school for _____years, that I have read, or if I cannot read or speak English, I have had it read to me, that the blank spaces have been filled in, and that I understand its permissions. I also certify that I have received a copy of all informed consent documentation.

Date: _____ Time: _____

Patient's Name (Print): _____

Patient's Signature: _____
(Minor Patient and parent Guardian Sign)

Witness Signature: _____

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ALCOHOL /SMOKING CONSUMPTION WARNING

Studies show that a common belief is that smoking causes the cessation of an appetite, which will in turn cause weight loss. Although it is true that smoking decreases one's appetite, it is **not** the healthy way of losing weight. Smoking has shown to have severe adverse effects on the body including respiratory (breathing) disorder and cancer. If you are a smoker, the Lap Band can be thought of as a replacement for suppressing your hunger, as you will get full quicker with smaller amounts of food. There are no adverse effects to drinking small amounts of alcohol with weight loss surgery. Alcohol is a high calorie liquid, and as such, should be limited, especially during the weight loss period. Thus, occasional drinking is allowable.

Keep in mind alcohol is processed in the body as sugar and the added sugar in mixed drinks.

- DO NOT drink alcohol during the rapid weight loss period.
- When drinking, remember that small amounts of alcohol can cause intoxication or can result in low blood glucose with serious consequences.
- DO NOT drive or operate heavy equipment after drinking alcohol-even small amounts.
- Eat if you plan to have a drink.
- Make certain to take your bariatric vitamin and mineral supplements

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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