

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW
**Weight Loss Surgery Post-Operative Laboratory - SUR
 and Checkout Orders**

No Orders Check Results in _____

PATIENT IDENTIFICATION LABEL
 (Place Referring MD label on back)

Ordering Physician: Please LEGIBLY print FIRST and LAST NAME if different than label.

1) _____ DR.# _____

If resident/fellow, list attending physician for billing purposes.

1) _____ DR.# _____

DIAGNOSIS / DIAGNOSIS CODES (ICD-9) - OUTPATIENTS ONLY:
Check at least one of the following diagnoses:

Morbid Obesity Surgical Malabsorption
 Vitamin Deficiency Achlorhydria
 Diabetes Other _____

**Tests ordered on Medicare outpatients must follow HCFA rules regarding medical necessity and FDA approval guidelines; and must include diagnosis, symptoms or the reasons for testing as indicated in the medical record. If *testing does not come under Medicare guidelines for payment, a signed Advance Beneficiary Notice must be included.*

If history of diabetes or borderline diabetes before surgery, check tests below.

Code	CHEMISTRY	Coll Vol
GLYHB	Hemoglobin A1c (glycosylated)	P 0.5-2
UMALRA	Microalbumin, Random, Quantitative	UR 1

The following tests should be ordered at 3 months post-op and annually. Check all tests below.

Code	CHEMISTRY/HEMATOLOGY	Coll Vol
BLIP	Lipids: CHOL, TRIG, HDL, LDL calculation*	GG 1-2
CCOMP	Comprehensive Metabolic: Na, K, Cl, CO ₂ , CR, BUN, GLU, CA, ALB, ALKP, ALT, AST, BILT, TP	GG 0.6-1
CBC	CBC & Platelet*	P 0.3-1
CU	Copper	DB 1.2-4
FERTN	Ferritin*	RG 0.4-1
FOLIC	Folic Acid (folate), serum	RG 0.9-2
HCY	Homocysteine	PI 1.2-3
MG	Magnesium*	GG 0.3-1
PHOS	Phosphorus	GG 0.3-1
PTHI	Parathormone	P 4
VITAA	Vitamin A (protect from light)	RF 0.6-2
VITB1	Vitamin B1 (protect from light)	PF 1.6-6
VITB2	Vitamin B2	P 1.2-4
VITB6	Vitamin B6 (protect from light)	PF 0.6-2
VB12	Vitamin B12	RG 0.8-1
VITD	Vitamin D (D2 & D3) 25-Hydroxy	RG 0.6-1
ZNC	Zinc	DB 1.8-4

ADDITIONAL LAB TESTS

RADIOLOGY

Reason for Order (Diagnosis and/or ICD 9): _____

Test/Exam/Procedure

Endoscopy
 ___ Patient has post-op GERD
 ___ Post GIB wt gain – measure pouch size and stoma diameter
 ___ GERD
 ___ Other _____

Upper Gastrointestinal Series
 ___ UGI to assess Adjustable Gastric Band pouch:
 Please use “adjustable band protocol”
 Routine surveillance (annual) Nausea/Vomiting
 Reflux/Heartburn R/O Prolapse
 ___ UGI to assess staple line breakdown

MRCP

CT of Abdomen and Pelvis
 ___ With IV and Oral Contrast
 ___ Without IV and Oral Contrast
 ___ Other _____

Non Invasive Test/Procedure/Exam
 ___ Right Upper Quadrant Ultrasound
 ___ Ultrasound Venous – Ext Bilateral
 ___ Ultrasound Venous – Unilateral
 ___ Chest X-Ray
 ___ EKG

Please obtain lab results from your primary care provider.

Fax results to 612-624-1473 to the attention of Dr. Andrade, Dr. Buchwald, Dr. Ikramuddin, Dr. Kellogg, Dr. Leslie, Kristi Kopacz PA or Donna Schneider CNP.

Section of Gastrointestinal Surgery, Department of Surgery
 420 Delaware Street SE, MMC 290, Minneapolis, MN 55405

Code	URINE, RANDOM	Coll Vol
UAI	Urinalysis*	UR 3

Requesting Provider Signature _____ Date _____ Time _____

- Return appointment needed in _____ days / weeks / months / years _____ **with NP** _____ **with MD**
- Return appointment needed in _____ days / weeks / months / years with dietician.
- Consult/Referral to: _____
- No follow up needed. May be seen as necessary.
- Return Band Assessment Clinic appointment needed in about _____ week(s) / _____ month(s) with provider.
(Please note the follow-up interval should never exceed 6 months.)
- Vitamin B12 1000 mcg IM or SQ and teach

Additional instructions/comments/plan of care:

Date Results Completed: _____

MD/NP comment/orders/instructions:

- _____ is low / high.
 - Recheck _____ in _____ days/ months.
- Start taking _____ .
 - Take for _____ days/ weeks/ until further instruction.
- Follow up with primary care doctor in _____ week(s)/ month(s).

Patient Notified by: _____ phone _____ letter
 _____ Patient instructed to return to clinic
 _____ Patient instructed to call