

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

PATIENT IDENTIFICATION LABEL
 (Place Referring MD label on back)

No Orders Check Results in _____

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:

278.01 Morbid Obesity 579.3 Surgical Malabsorption

268.9 Vitamin D Deficiency 269.2 Vitamin Deficiency

250.01 Type 1 Diabetes 250.00 Type 2 Diabetes

536.0 Achlorhydria 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 * & bold 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	Glycated Hemoglobin, A1C*	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

	Code	URINE, RANDOM	Coll Vol
	UAI	Urinalysis*	UR 3
	URC	Urine Culture* if UA positive	UR 1

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
 Perioperative Band Evaluation Other: _____

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

UMMC, Fairview SLEEP CENTER
 606 24th Ave. S. Ste 102 Mpls, MN 55454
 Ph: 612-273-3396 Fax: 612-273-4790

Reason for order (Diagnosis and/or ICD 9): BMI = _____ (please fill in)

___ OSA preliminary 327.23
 ___ OSA known diagnosis 327.23
 ___ Other _____

___ Routine Polysomnogram: Split night with CPAP/bilevel titration
 Transcutaneous CO₂ monitoring if BMI >40.
 Return visit in 2 weeks after sleep study to consult with sleep center MD/NP.
 Letter of clearance/recommendations relating to bariatric surgery.

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
 507753 4/21/09

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.
- Return appointment needed in _____ days / weeks / months with bariatric care coordinator team.
- 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