

Entered: __/__/20__

Initials: _____

Verified: __/__/20__

Initials: _____

For office use only.

Health Care Utilization form (HC) – Version 06/15/2006

Patient ID _____

Form Completion Date __/__/20__
mm dd yy

Certification number: _____

Visit: _____

Instructions: This form should be completed for each hospitalization or out-patient procedure that was reported by the patient in the last 6 or 12 months. Note, at the 6 or 12 month visit use the time frame “last 6 months.” At the 24 month visit use the time frame “last 12 months.”

1. Name and Address of hospital/clinic:

Name: _____ Address: _____
City: _____ St: _____ Zip: _____

2. Admission/treatment date: __/__/20__ (mm/dd/yy)

3. Treatment/care utilized: 1. Hospitalization 2. Out-patient procedure

** for hospitalization only**

3.1 Discharge location: 1. Home 2. Rehabilitation facility 3. Skilled nursing facility 4. Other hospital 5. Other _____
3.2 Discharge Date: __/__/20__ mm dd yy 3.3 If not discharged to home, specify length of care at facility _____ (days) or other hospital:

4. Reason for treatment/care (check no or yes to each)

No Yes

GI Tract or Bariatric Surgery Related Diagnoses

If yes,

No Yes
 Stomal/gastric outlet obstruction
 Small bowel obstruction
 Deep wound infection
 Other wound complication
 Infection from GI leak
 GI bleeding
 GI tract symptoms
 Hypovolemia
 Hernia without complication
 Hernia with complication
 Abdominal pain
 Abdominal abscess
 Ulcer disease
 Nausea and vomiting
 Excess skin
 Other GI tract or surgery related diagnosis
(Specify: _____)

No Yes

Vascular System Diagnoses

If yes,

No Yes
 Chest pain or angina
 Myocardial infarction
 Congestive heart disease
 TIA/Stroke
 PE/DVT
 Other vascular system related diagnosis
(Specify: _____)

No Yes

Respiratory System Diagnoses

If yes,

No Yes
 Acute respiratory failure
 Pulmonary hypertension
 COPD
 Obstructive lung disease
 Pneumonia
 Other respiratory system related diagnosis
(Specify: _____)

No Yes

Renal System Diagnoses

If Yes,

No Yes
 Acute renal failure
 Kidney failure or start of dialysis
 Severe hypoglycemia
 Pancreatitis
 Other renal system related diagnosis
(Specify: _____)

No Yes

Obesity-Related Diagnoses

If yes,

No Yes
 Osteoarthritis
 Cellulitis
 Obstructive lung disease
 Other obesity related diagnosis
(Specify: _____)

Continued on next page...

HEALTH CARE UTILIZATION FORM (HC)

<p>PURPOSE:</p> <p>PERSON(S) RESPONSIBLE:</p> <p>SOURCES OF INFORMATION:</p> <p>WHEN TO ADMINISTER FORM:</p> <p>GENERAL INSTRUCTIONS (Patient)</p> <p>GENERAL INSTRUCTIONS: (Clinician)</p> <p>SCORING ALGORITHM:</p>	<p>To collect hospitalization and/or out-patient procedure information on patients aged 18 years or older enrolled in LABS-2, at their 6-month, one year appointment and subsequent annual follow-ups following bariatric surgery.</p> <p>Clinician/Coordinator Surgeon</p> <p>Patient/medical chart</p> <p>At the 6-month, one year follow-up appointment for LABS-2 and annual follow-up appointment thereafter.</p> <p>The coordinator or other study staff must review the document at patient's clinic visit to ensure that all fields have been completed appropriately.</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>
DATA SECTION	COMPLETION INSTRUCTIONS
<p>PATIENT ID:</p> <p>VISIT:</p> <p>FORM COMPLETION DATE:</p>	<p>Record the patient's ID number. The ID number is assigned via the ID registration application of the MATRIX Web Data Management System (MATRIX). Instructions on using this application are included in the MATRIX Manual.</p> <p><i>NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.</i></p> <p>Record the visit number that the HC corresponds to on the right hand corner of the cover page.</p> <p>Record the date of form completion (mm/dd/20yy).</p> <ol style="list-style-type: none"> 1. Record the name and address of the hospital/clinic where the hospitalization or out-patient procedure occurred. 2. Record the admission or treatment date.

DATA SECTION	COMPLETION INSTRUCTIONS
	<p>3. <i>Hospitalization</i> = admitted for >23 hours. <i>Out-Patient</i> = any out-patient procedure or hospital admittance ≤ 23 hours should be included as out-patient.</p> <p><u>If "hospitalization"</u> then complete 3.1, 3.2 and 3.3. <u>If "out-patient"</u> then skip to 4.</p> <p>3.1 Record which location the participant was discharged to.</p> <p>3.2 Record the date when the participant was discharged.</p> <p>3.3 Record how many days the participant stayed at a facility (rehabilitation, skilled nursing facility or other hospital) post-discharge from the initial hospitalization.</p> <p>4. Record “Yes” or “No” for each treatment/care for GI Tract or Bariatric Surgery Related Diagnoses, Renal System Diagnoses, Vascular System Diagnoses, Respiratory System Diagnoses, Obesity-Related Diagnoses and Other Diagnoses.</p> <p>5. Record “Yes” or “No” if the treatment/care was confirmed by medical discharge summary/medical records. If the medical records were ordered, but not yet received, record -1. The MATRIX system will continue to prompt you for the missing information on the Edit Report as a reminder.</p> <p>6. Record “Yes” or “No” for each operation(s)/procedure(s) performed during this hospitalization/out-patient procedure for GI tract or Bariatric Surgery Related Procedures, Renal System Procedures, Vascular System Procedures, Respiratory System Procedures, Elective Procedures and Other Procedures.</p>

DATA SECTION	COMPLETION INSTRUCTIONS
	<p>7. Record “Yes” or “No” if the operation(s)/procedure(s) was confirmed by medical discharge summary/medical records. If the medical records were ordered, but not yet received, record -1. The MATRIX system will continue to prompt you for the missing information on the Edit Report as a reminder.</p> <p>8. Record “Yes” or “No” if the hospitalization/out-patient procedure was for an operation.</p> <p><u>If "Yes"</u> complete 8.1.</p> <p>8.1 Record “Yes” or “No” if the procedure was for an abdominal re-operation.</p> <p><u>If "Yes"</u>, record if the approach was laparoscopic, laparoscopic converted to open or open.</p>