Operative Treatment Consent Agreement:

The purpose of this legal document is to confirm in the presence of witnesses that you wish to proceed with Mini-Gastric Bypass.

You are asked to read this document very carefully!
As you read each paragraph, you are encouraged to discuss any questions about it with friends, family, nurses, other doctors and your surgeon.

If you agree with everything in each paragraph as you read it you are asked to:

1. Write your initials next to each paragraph
2. Check the box next to each paragraph
3. Write at least two sentences or more describing the paragraph and showing your understanding of what you have read.

Explanation of this Process: (Reading this Form, Your Initials and Re-Writing What You Read)
As you read this form you are asked to carefully consider the issues that are addressed in each paragraph. As a demonstration that you have read and agree with each issue, you will be asked to place your initials next to the paragraph(s) that you have just read and then to rewrite in your own words, the issue addressed in the paragraph(s) that you just read, showing that you understand and agree with the issues addressed.

Preoperative Education
I understand that I have been given extensive preoperative education and information about obesity, the risks of obesity and the risks and possible benefits of the surgical procedures in general and the Mini-Gastric Bypass in particular. I understand that this consent form is designed to provide a written confirmation of these discussions with my surgeon and The Centers for Laparoscopic Obesity Surgery support staff and the extensive educational process that I have participated in by repeating and recording some of the more significant medical information given to me.

I understand that this long document is intended to educate me and make me think over my decision to have surgery once again. I confirm that my family, my Doctor and I have extensively reviewed the decision to proceed with this surgery. This document is a written record of my efforts to be well informed about my decision to proceed with operation. I can confirm that I wish to consent to go forward with the proposed Mini-Gastric Bypass procedure.

If you agree that everything in the above paragraph is correct, check Yes Here:

Write a description of the previous paragraph and comments (More than two sentences): ________
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Condition/Diagnosis:
I understand that obesity has, in some patients, been shown to be dangerous, unhealthy and increases my risk of death from a variety of medical illnesses. I understand that some scientific studies conclude that obesity places individuals at increased risk of disability, 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. I understand these issues from my own experience, my discussions with my family, my discussions with my doctor and from the very extensive reading and discussions with patients of CLOS and my surgeon. From this careful investigation, I believe strongly that I should be considered for surgery.

If you agree that, everything in the above paragraph is correct, check Yes Here:

Write a description of the previous paragraph and comments (More than two sentences): ________
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Surgical Procedure:

The Mini-Gastric Bypass: I understand that the procedure that my surgeon has recommended is the Mini-Gastric Bypass. My surgeon with the help and assistance of the staff of The Centers for Laparoscopic Obesity Surgery, my doctor, my family and many patients that have undergone Mini-Gastric Bypass have provided me with a detailed explanation of the medical history of the development of the surgical treatment of obesity, gastric surgery as a treatment of obesity, the development of laparoscopic (minimally invasive) surgery and the Mini-Gastric Bypass. I have been provided with drawings, photographs, written and verbal descriptions of the operation and other alternative surgeries including the "Sleeve" Gastrectomy, Open Roux-en-Y Gastric Bypass, Laparoscopic Roux-en-Y Gastric Bypass, Slapstick Ring Vertical Gastric Bypass (Fobi Pouch), Micro pouch Gastric Bypass, Antecolic Laparoscopic Roux-en-Y Gastric Bypass, Long Limb Gastric Bypass, Biliopancreatic Diversion, Biliopancreatic Diversion with Duodenal Switch, Gastric Band, Laparoscopic Gastric Band, Laparoscopic Adjustable Gastric Band, Vertical Banded Gastroplasty, Laparoscopic Vertical Banded Gastroplasty and others.

I have talked with patients that have previously undergone the Mini-Gastric Bypass surgery. I have made every reasonable effort to investigate and understand the details of the operation. I believe that my surgeon and the staff of CLOS have gone beyond what many other doctors do to inform me of the risks and benefits of the surgery and to assist me in making a good decision about obesity and surgery for obesity.

If you agree that, everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences): ____________________________
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Medical Controversy

I affirm here unequivocally and without reservations that I understand that medical care often involves major controversy. I clearly recognize that weight loss surgery now is filled with controversy: sleeve gastrectomy, gastric banding types of surgery vs. bypass types of surgery, proximal gastric bypasses vs. distal gastric bypasses, bypass type surgery vs. the duodenal switch vs. the Fobi pouch and the new Adjustable Gastric Band. The list of disagreements about whether to have surgery and what kind of surgery is best is extensive.

I understand that there are many different types and variations in the surgical procedures being performed for weight loss in America and around the world at this time. I also know that although many studies document the value of surgery for obesity, there remain many physicians and surgeons who are opposed to the idea of any form of surgical treatment of obesity.

I know that because of the numerous problems and complications that can occur with weight loss surgery many physicians and surgeons prefer to avoid bariatric surgery entirely. I clearly realize that there are a variety of different Types of weight loss surgery, some of which are shown in the table below.

Table 1: Different Types of weight loss surgery

<table>
<thead>
<tr>
<th>Types of weight loss surgery</th>
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<tbody>
<tr>
<td>Open Roux-en-Y Gastric Bypass</td>
</tr>
<tr>
<td>Laparoscopic Roux-en-Y Gastric Bypass</td>
</tr>
<tr>
<td>Silastic Ring Vertical Gastric Bypass (Fobi Pouch)</td>
</tr>
<tr>
<td>Micro pouch Gastric Bypass</td>
</tr>
<tr>
<td>Antecolic Laparoscopic Roux-en-Y Gastric Bypass</td>
</tr>
<tr>
<td>Long Limb Gastric Bypass</td>
</tr>
<tr>
<td>Biliopancreatic Diversion</td>
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<tr>
<td>Biliopancreatic Diversion with Duodenal Switch</td>
</tr>
<tr>
<td>Gastric Band</td>
</tr>
<tr>
<td>Laparoscopic Gastric Band</td>
</tr>
<tr>
<td>Laparoscopic Adjustable Gastric Band</td>
</tr>
<tr>
<td>Vertical Banded Gastroplasty</td>
</tr>
<tr>
<td>Laparoscopic Vertical Banded Gastroplasty</td>
</tr>
<tr>
<td>Sleeve Gastrectomy</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
</table>

I understand that it is Dr. Rutledge’s medical opinion that no one of these surgical choices is necessarily bad, but I recognize that each type of surgery has its own associated risks and complications. Their risk and complications have kept all of them from being universally adopted. It demonstrates that surgery for obesity has not yet reached a "perfect" surgical solution. The number and the great variety of the different types of surgery offered for the treatment of obesity and the acrimony and disagreement between practitioners over the selection of the surgical technique suggests that there are opportunities for further improvement of the presently available weight loss surgery. It means that continued assessment of innovations in surgical procedures is appropriate.

I have spent significant time and effort evaluating this question and I believe that the presently available operations for the treatment of obesity can and should be offered to obese individuals. I feel that the need for treatment of obesity is great and that all of the medical, drug and surgical solutions that we have at present are imperfect.
I know that I could have chosen any one of these other types of surgical procedures but after a slow careful and deliberate investigation, I have decided to have the Mini-Gastric Bypass. I know that the Mini-Gastric Bypass is not perfect; I know that certain risks and complications can occur, but after reviewing all of the information, I feel comfortable that my family, my doctor and I agree that the Mini-Gastric Bypass is the best choice for me.

If you agree that, everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): ____
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The "old loop" Gastric Bypass

I know that some critics of the Mini-Gastric Bypass have compared it to the "old loop" Gastric Bypass. The following figures and discussion explain the differences between the Mini-Gastric Bypass, the Standard Billroth II and the "old loop" Gastric Bypass.

Billroth II Gastro-jejunostomy

The Billroth II is the most commonly performed type of connection between the stomach and the small bowel. By a margin of 4 to 1, the Billroth II is preferred over the Roux-en-Y when general surgeons choose to connect the stomach to the bowel. The Billroth II is a surgical procedure used routinely in the treatment of trauma, stomach cancer and peptic ulcers. Every year over approximately 16,000, Billroth II surgeries are performed in America alone. In the usual Billroth II, the esophagus and the body of the stomach are distant from the Billroth II connection.

The Billroth II connects the stomach to the jejunum, the upper-middle portion of the small intestine. Like the Mini-Gastric Bypass, the standard Billroth II places the connection between the stomach and the small bowel low on the stomach at the junction between the body and the antrum of the stomach. The lower part of the stomach that is often removed in the usual Billroth II surgery.

Figure 1: Standard Billroth II Gastrojejunostomy.

I know that I do not have to have this kind of surgery. I know that the Mini-Gastric Bypass is a form of gastric bypass that uses the Billroth II type of connection. I know that some surgeons and other doctors do not like the Billroth II type of connection. I am aware of this and want to go ahead. I have weighed the risks and benefits of the surgical techniques used in the MGB and I favor the Billroth II type connection used in the MGB.

If you agree that, everything in the above paragraph is correct, check Yes Here: ?
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): ___
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The "old loop" Billroth II Gastro-jejunostomy

I know that there was an "old loop" Gastric Bypass which included a small stomach pouch that was placed high up on the stomach next to the esophagus. The loop that carries bile was placed close to the esophagus and this led to the associated problems with esophagitis that occurred with the "old loop" type gastric bypass. This configuration is in many ways much like the common general surgical procedure called a total gastrectomy. It is widely agreed that a total gastrectomy is not
a good choice for a Billroth II reconstruction. This "old loop" is different from the Mini-Gastric Bypass. The "old loop" created a stomach pouch that was also based upon the outside edge of the stomach. This kind of pouch commonly stretches leading to failure of weight loss.

The Mini-Gastric Bypass

The Mini-Gastric Bypass does have a Billroth II type loop connection like the "old loop" bypass, but the loop in the Mini-Gastric Bypass is placed low on the stomach far away from the esophagus. This is in the same position as the loop in the standard Billroth II done for trauma, ulcers, cancer and other diseases.

The Mini-Gastric Bypass creates a long narrow "gastric tube" that places the connection of the stomach and the bowel low in the stomach and keeps the stream of bile away from the esophagus. The other advantages are that the surgery is easily accessible in the event that the surgery needs to be revised.
**Mini-Gastric Bypass Results:**
I understand that at the present time over 5,500 total Mini-Gastric Bypass operations have been performed. I understand that the overall complication rate in the Mini-Gastric Bypass patients at this time is 5%. I know that three patients died in the first month following surgery giving an overall 30-day mortality rate of 0.05%.

I know that the overall average hospital stay for Mini-Gastric Bypass patients to date has been 1.1 days. I know that I will probably be discharged from the hospital the afternoon following surgery, the day after my surgery. I am ready for this and have arranged for travel from the hospital and for care at home.

If you agree that, everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):


**Risks/Benefits of Proposed Procedure:**
Just as there are expected and hoped for benefits from the Mini-Gastric Bypass, I understand that all medical and surgical procedures, including the Mini-Gastric Bypass involve risks. I have been told and I understand that my weight increases my risks of these problems and complications. The following table lists some of the risks known to follow the MGB.

These risks include:

<table>
<thead>
<tr>
<th>Complications</th>
<th>description</th>
<th>If you agree and understand check Yes Here: †</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic Reactions</td>
<td>All kinds of allergic drug and chemical reactions are possible from my treatment, from minor reactions such as a rash to sudden overwhelming reactions that can cause death.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Anesthetic Complications</td>
<td>I know and consent to the fact that general Anesthesia will be used to put me to “sleep” for the operation. I am aware that the anesthesia has major and minor risks that can be associated with a variety of different complications up to and including death.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Feeling Sick, Nausea And Vomiting</td>
<td>Some operations, anesthetics and pain-relieving drugs are more likely to cause sickness (nausea) than others. Sickness can often be treated with anti-vomiting drugs (anti-emetics), but it may last from a few hours to several days.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>I know I will have a tube in my airway to breathe for me during surgery and that it may give me a sore throat. The discomfort or pain lasts from a few hours to days.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Dizziness, Blurred Vision</td>
<td>I know that the anesthetic or loss of fluids may lower my blood pressure and make me feel faint.</td>
<td>And initial here:</td>
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<tr>
<td>Shivering</td>
<td>This may be due to my getting cold during the surgery, to some drugs, or to stress.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Headache</td>
<td>This may be due to the effects of the anesthetic, to the surgery, to lack of fluids, or to anxiety. More severe headaches may occur after a spinal or epidural anesthetic.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Surgery involves incisions and cutting that can result in bleeding complications, from minor to massive, that can lead to the need for emergency surgery, transfusion or death.</td>
<td>And initial here:</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>In addition, blood clots, also called Deep Vein Thrombosis (DVT) and Pulmonary Embolus can sometimes occur after surgery and may cause death. I understand that I need to get out of bed the evening after surgery, move, and flex my feet and legs to try to help prevent clots from forming in my legs.</td>
<td>And initial here:</td>
</tr>
<tr>
<td></td>
<td>I know that surgery can result in an infection, Including wound infections, bladder infections, pneumonia, skin infections and deep abdominal infections that can sometimes lead to death.</td>
<td>And initial here:</td>
</tr>
</tbody>
</table>
Infection

Leak

I know that after weight loss operations on the stomach the new connections can leak. The leak can allow stomach acid, bacteria and digestive enzymes to escape into the abdomen causing a severe and potentially lethal infection and or abscess.

I am aware that the surgical complication most commonly related to an increased morbidity and mortality is a suture line leak. I am well aware that this is a technically demanding operation and that a leak rate of 2 to 5% for gastric bypass surgeries and 0.5% for banding procedures is frequently reported. I know that if a leak is suspected, I may need to undergo x-ray testing or emergency surgery. I am aware that emergency surgery may be needed and that multiple drains may need to be placed. I know that patients with a leak may also need to be in the intensive care unit for an extended period of time, sometime weeks or months, and I and my family clearly understand that the complication can be lethal.

If you agree and understand check Yes Here: †
And initial here:

Narrowing (stricture)

Narrowing (stricture), inflammation and/or ulceration of the connection between the stomach and the small bowel can occur after the operation this can require emergency operation, intensive care and can sometimes lead to death. To protect my new stomach from ulcers I must never again take aspirin, or aspirin like drugs such as Motrin, Ibuprofen, Naproxen, Relafen or other similar drugs.

If you agree and understand check Yes Here: †
And initial here:

Indigestion, Acid/Bile Reflux or Ulcers

I know that the operation can sometimes lead to severe nausea, vomiting, indigestion, abdominal pain, gastritis or ulcers. This can be severe and can last for days, weeks and possibly even longer. This is especially likely if I have had previous problems with nausea, abdominal pain or ulcers. Nausea is much more common in women than men. Women that have been treated with any type of hormone therapy (Premarin, Estrogen or birth control pills) are much more likely to have nausea and vomiting after surgery. Chronic gastritis has been found in some patients years after the Billroth II surgery. Biliary duodeno-gastro-esophageal reflux can be injurious on the mucosa of the stomach and the esophagus. Bile reflux if it occurs and causes problems the operation can be revised. I know that in most cases, revision is not necessary.

If you agree and understand check Yes Here: †
And initial here:

Ulcers

I know that the operation can sometimes lead to severe nausea, vomiting, indigestion, abdominal pain, gastritis or ulcers. This can be severe and can last for days, weeks and possibly even longer. This is especially likely if I have had previous problems with nausea, abdominal pain or ulcers. Nausea is much more common in women than men. Women that have been treated with any type of hormone therapy (Premarin, Estrogen or birth control pills) are much more likely to have nausea and vomiting after surgery. Chronic gastritis has been found in some patients years after the Billroth II surgery. Biliary duodeno-gastro-esophageal reflux can be injurious on the mucosa of the stomach and the esophagus. Bile reflux if it occurs and causes problems the operation can be revised. I know that in most cases, revision is not necessary.

I know that I may develop an ulcer after surgery. I know I need to avoid ulcer causing foods, habits and medications. I know in some cases the ulcer may require surgery or reversal of my surgery. I know that studies of patients that have had partial removal of their stomach (Post gastrectomy) can have a variety of different complications.

In one study ulcers occurred in 2% of patients, Diarrhea (16%), Dumping (14%), Bilious vomiting (10%), Iron deficiency anemia (12%), B12 deficiency (14%) and Folate deficiency (32%). I understand these risks and I am ready to treat them if needed. I know that Dr. Rutledge recommends that I should not drink alcohol, take aspirin-like drugs, drink coffee or soda pop as these may increase the chances of ulcers and gastritis.

If you agree and understand check Yes Here: †
And initial here:

Post-gastrectomy (Stomach Removal) Problems

I am fully aware that numerous problems can follow stomach removal surgery. These “post-gastrectomy” problems may occur early after surgery or many months or years later. The early problems relate to the surgery itself. There are many late post-gastrectomy syndromes; these may be more disabling than the dyspeptic symptoms that led to the surgery in the first place.

Complications of gastric surgery: Esophagus; Gastroesophageal reflux, Dysphagia Stomach; Delayed gastric emptying, Bezoars, Outlet obstruction, Stomatitis, Recurrent ulcers, Stump carcinoma, Afferent loop syndrome, Small intestine Diarrhea, Dumping syndrome, Bacterial contamination syndrome, Unmasked celiac disease, unmasked pancreatic insufficiency or unmasked lactase deficiency, weight loss and malabsorption, (Iron, Folate, Vitamin B12, Thiamine (vitamin B1), Calcium, Fats, and Anemia.) Gallbladder Cholelithiasis

If you agree and understand check Yes Here: †
And initial here:
| **Bile Reflux** | I know that reflux of bile acids into the esophagus may contribute to injury of the esophageal lining. Bile is a component of digestive juices normally present in the small intestine. Bile can reflux from the small intestine into the stomach and does so normally. However, in a subset of people who have severe GERD (backwashing of acid and bile into the esophagus), including in those who have Barrett’s esophagus, there is an increase for back washing into the esophagus. Although acid plays a primary role in the development of Barrett’s esophagus, there is evidence that bile, reflux adds to the effect of acid injury to the esophagus and therefore may contribute to the development of Barrett’s esophagus and possibly esophageal adenocarcinoma (cancer). | If you agree and understand check Yes Here: †
And initial here: |
| **Dumping Syndrome** | I know that the Dumping Syndrome (Symptoms of the dumping syndrome include cardiovascular problems with weakness, sweating, nausea, diarrhea and dizziness) can occur in some patients after gastric bypass. This can be so severe that the surgery may have to be reversed or revised. | If you agree and understand check Yes Here: †
And initial here: |
| **Bowel Obstruction** | I know that any abdominal operation can leave behind scars that can put the patient at risk for later bowel blockage or obstruction. The bowel can twist, obstruct and even perforate leading to serious complications and even death. | If you agree and understand check Yes Here: †
And initial here: |
| **Laparoscopic Surgery Risks** | I know that laparoscopic surgery uses punctures to enter the abdomen and this can lead to abdominal organ and/or blood vessel injury, bleeding and even death. | If you agree and understand check Yes Here: †
And initial here: |
| **Side Effects of Drugs** | All drugs have inherent risks and complications and in some cases can cause a wide variety of side effects, reactions in some cases including death. | If you agree and understand check Yes Here: †
And initial here: |
| **Loss of Bodily Function** | I know that the performance of surgery and anesthesia can stress the body’s systems leading to a variety of complications including nerve damage, stroke, heart attack, limb loss and other problems related to operation and anesthesia. | If you agree and understand check Yes Here: †
And initial here: |
| **Risks of Transfusion** | I know that blood and blood products are potentially dangerous with the risk of infections, including Hepatitis and Acquired Immune Deficiency Syndrome (AIDS), from the administration of blood and/or blood components. These illnesses are serious and can be fatal. | If you agree and understand check Yes Here: †
And initial here: |
| **Hernia** | I know that cuts and incisions in the abdominal wall can lead to hernias after surgery. Hernias can lead to pain, bowel blockage, obstruction and even perforation and death in some cases. Treatment of hernias usually requires another operation. | If you agree and understand check Yes Here: †
And initial here: |
| **Hair Loss** | I know that many patients develop hair loss for a period after operation. When this occurs it usually starts around 3-4 months after surgery and resolves at 7-9 months after operation. I know that this usually responds to increased oral intake of protein and vitamins but it may be permanent. | If you agree and understand check Yes Here: †
And initial here: |
| **Vitamin and Mineral Deficiencies** | I know that after gastric bypass there is a malabsorption of some vitamins and minerals. I know patients must take vitamin and mineral supplements forever to protect themselves from these problems. I know that I also need to have yearly blood tests to measure the blood levels of these vitamins and minerals.

*** I know there is a risk of Wernicke’s encephalopathy and other rare nerve and brain damage if I do not carefully follow these instructions. **Wernicke’s encephalopathy is a severe syndrome characterized by loss of short-term memory. It is linked to brain damage and is the result of inadequate intake or absorption of thiamine (Vitamin B1) coupled with continued carbohydrate ingestion.***

I know that this is very important: I know that I must take vitamin and mineral supplements continuously and forever. I understand that in some cases the deficiencies are so severe that they can lead to nerve and brain damage and the operation must be reversed. | If you agree and understand check Yes Here: †
And initial here: |
### Inadequate Weight Loss

I know that I might not lose enough weight.

**WARNING:** Remember that you might not lose weight after the operation. You might gain weight and all kinds of problems with your weight after surgery. *There are patients that will fail any type of surgery. Inadequate weight loss is a risk of all types of weight loss surgery and indeed of all types of weight loss treatment.*

*I recognize that the Mini-Gastric Bypass is not by any means a perfect treatment and that one of the risks that I face is a real possibility of inadequate weight loss following my Mini-Gastric Bypass surgery.*

If you agree and understand check Yes Here: †
And initial here:

### Excessive Weight Loss

I clearly understand that there is a risk that I might suffer malnutrition and lose too much weight.

I am well aware that some patients sustain excessive weight loss after weight loss operations.

I understand that excessive weight loss may require surgical revision or reversal of the bypass to prevent severe malnutrition, nausea or vitamin and mineral deficiencies or even death.

I understand that almost 1% of patients lose too much weight following weight loss surgery and need to have surgery to reverse the excessive weight loss.

As part of this agreement, I promise and agree to monitor my weight and health carefully and if excessive weight loss occurs, I will submit to early and appropriate treatment.

I hereby formally and unequivocally state that I am prepared for this possibility of malnutrition and excessive weight loss and can afford to see Dr. Rutledge and C.L.O.S. to pay for and receive the appropriate surgical treatment of a revision if necessary.

I understand and expect that the costs of surgery to reverse or revise surgery will be roughly the same as the initial surgery.

If you agree and understand check Yes Here: †
And initial here:

### Complications of Pregnancy

I understand that obese pregnant women are at high risk for adverse perinatal outcome. I am also aware that there are well known risks to the patient and the baby after surgery for morbid obesity. Vitamin and mineral deficiencies can put the newborn babies of gastric bypass mothers at risk.

No pregnancy should occur for the first one to two years after operation. **Gastric Bypass has been shown to cause multiple types of vitamin and mineral deficiencies including: iron, B12, Folate, Thiamine, calcium and many others. Many of these deficiencies have been shown to cause birth defects or are suspected that they could cause birth defects.** We also know that many patients who lose weight feel that they are well after surgery and forget to take their vitamins. I understand and take full responsibility to be certain not to miss any of my vitamins and obtain obstetric consultation if I decide to go ahead with pregnancy following surgery. I understand all of these risks fully and request that Dr. Rutledge proceed with surgery.

If you agree and understand check Yes Here: †
And initial here:

### Unplanned Pregnancy

**Warning to women using Oral Contraceptives (Birth Control Pills):** More than 80 million women worldwide take "the pill" to prevent pregnancy. Typical failure rates among pill users are as high as 12% to 20% in some surveys. Other factors have been shown to increase the risk of pill failure: smoking, diarrhea and/or vomiting drug interactions, systemic illness, psychological stress, and menstrual disturbances. Therefore, it is important to recognize that Birth Control Pills may not be an effective method of birth control after the Mini-Gastric Bypass until those factors have resolved. We have found on several occasions that in many cases the hormonal methods of birth control fail after Mini-Gastric Bypass. Couples need to plan another form of non-hormonal birth control for 6-12 months after surgery. Depo-Provera has also been associated with marked cases of nausea in post MGB patients. An unplanned pregnancy can be one of life's most difficult experiences.

If you agree and understand check Yes Here: †
And initial here:

### Other

I know that major abdominal surgery, including the Mini-Gastric Bypass, is associated with a large variety of other risks and complications, both recognized and unrecognized that occur both soon after and long after the operation.

If you agree and understand check Yes Here: †
And initial here:
| Depression | I know that depression and anxiety are common medical illnesses and have been found to be particularly common after weight loss operations. | If you agree and understand check Yes Here: †  
And initial here: |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Osteoporosis| I know that weight loss procedures may be associated with the development of osteoporosis and bone disease. Osteomalacia (soft bones) and secondary hyperparathyroidism can occur in obese individuals who have not undergone any kind of gastric surgery. There is a long-standing recognition of a relationship between gastrointestinal surgery and the development of bone diseases (osteomalacia, osteitis fibrosa cystica, and osteoporosis.) In one study patients who had undergone gastric bypass had lost 8% of bone mass density. Similar results were found in other studies. Gastric surgery and weight loss in morbidly obese individuals cause increased bone resorption and increased bone loss. Treatment and prevention includes calcium and vitamin D supplementation and increased physical activity. I agree to monitor these factors lifelong by staying in touch with Dr. Rutledge and my local physician. I am aware that not following this advice can be deadly. | If you agree and understand check Yes Here: †  
And initial here: |
| Cancer      | I know that cancer can occur in anyone. Many cancers are more common in obese as compared to thin patients. Overweight men have a significantly higher rate of prostate cancer. Obese women have higher risks of developing breast cancer and cancer of the uterus and ovaries. It is expected, but not certain, that with weight loss you will have an overall decrease in your risk of cancer. The Billroth II connection used in the Mini-Gastric Bypass has been used for almost 100 years and is performed over 16,000 times a year in America to connect the stomach to the bowel. Some studies have suggested that the Billroth II connection used in the Mini-Gastric Bypass can increase the risk of stomach cancer while others do not show this. The studies showing increase risk of stomach cancer are in Billroth II patients that had the surgery for ulcers and since ulcers can cause an increased risk of stomach cancer it may be the stomach ulcer not the Billroth II that causes some studies to show increased risk of stomach cancer after the Billroth II. Diet seems to be much more important as a cause of stomach cancer. Eating processed meats has a much greater effect on increasing stomach cancer risk that the Billroth II. Conversely fresh fruits and vegetables seem to protect against stomach cancer. In the end no one knows what will happen in your case and if you are concerned about stomach cancer then you could choose not to have the Mini-Gastric Bypass | If you agree and understand check Yes Here: †  
And initial here: |
| Death       | This is a major and serious operation. It may lead to death from complications. | If you agree and understand check Yes Here: †  
And initial here: |

If you agree that everything in the above paragraph is correct, check Yes Here: †  
Initial the paragraph above  
Write a description of the previous paragraph and comments (More than two sentences): _______  
________________________________________________________________________________  
________________________________________________________________________________  
________________________________________________________________________________  

**Excessive Weight Loss**  
I clearly understand that there is a risk that I might suffer malnutrition and lose too much weight. I know that the diagnosis of excess weight loss is easy. I have excess weight loss if: I do not feel well and if my yearly blood tests that I have agreed to, show any forms of low values, abnormal values or deficiencies. I know that if I feel fatigue, weakness, if my friends, family or physician or acquaintances, comment on my weight or appearance I may have lost too much weight. At that moment I know that should, and by this agreement I hereby confirm, that I will arrange, to see Dr. Rutledge to confirm the presence of excess weight loss. I know that the Mini-Gastric Bypass can be easily reversed by Dr. Rutledge and that I stand ready and able to deal with this possibility by returning to see Dr. Rutledge in his clinic and having the surgery revised or reversed if necessary.
Furthermore, I now state that if I do not act in this clear and responsible manner that I cannot hold Dr. Rutledge responsible for bad outcomes of excessive weight loss, or to state the same thing another way; Dr. Rutledge cannot be expected to care for me if I do not return to see him, i.e. if I break the doctor patient relationship.

It is crystal clear to me that the mini-gastric bypass is powerful therapy, and that the mini-gastric bypass can cause the patient to lose too much weight. I know that too much weight loss if not treated can lead to severe complications and death. I also know that the excess weight loss from the Mini-Gastric Bypass can be easily reversed by a short operation.

I am well aware that some patients sustain excessive weight loss after weight loss operations. I understand that excessive weight loss may require surgical revision or reversal of the bypass to prevent severe malnutrition, nausea or vitamin and mineral deficiencies or even death. I understand that almost 1% of patients lose too much weight following weight loss surgery and need to have surgery to reverse the excessive weight loss.

As part of this agreement, I promise and agree to monitor, my weight and health carefully and if excessive weight loss occurs, I will submit to early and appropriate treatment.

Again in plain words: I know I can get too thin from an operation designed to cause weight loss. A weight loss surgery can only have three outcomes; perfect weight loss, inadequate weight loss and excess weight loss.

I am very well educated that I might lose too much weight and that I can easily have this issue of excess weight loss treated by revising the surgery. I know that I, the patient must take the responsibility of identifying the excess weight loss and seeking appropriate follow up with Dr. Rutledge. That responsibility is one I fully and completely accept. In the event that I fail to return to Dr. Rutledge for treatment I agree Dr. Rutledge is not responsible.

I know if I get too thin it can be fixed. I agree if I get too thin to come to Dr. Rutledge to get the problem fixed. If I do not come to get the problem fixed then that is completely my personal responsibility.

I understand and expect that the costs of surgery to reverse or revise surgery will be roughly the same as the initial surgery.

Write a description of the previous paragraph and comments (More than two sentences): ______

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**Risks of General Anesthesia**

I know that serious side effects of general anesthesia are well known to occur but fortunately are uncommon. General anesthesia suppresses the normal throat reflexes such as swallowing, coughing, or gagging that prevent aspiration. Aspiration occurs when materials, objects or liquids are inhaled into the respiratory tract (the windpipe or the lungs). To help prevent aspiration, an endotracheal (ET), breathing tube will be inserted during the surgery this is called “general anesthesia.”

When an ET tube is in place, the lungs should be protected so stomach contents cannot enter the lungs. Aspiration during anesthesia and surgery is uncommon, but does occur and is a risk of surgery especially in overweight or obese patients.

Insertion or removal of airway tubes for general anesthesia can cause respiratory problems such as coughing; gagging; muscle spasms in the voice box, or larynx (laryngospasm); or bronchial tubes in the lungs (bronchospasm).

Insertion of airways also may cause an increase in blood pressure (hypertension) and heart rate (tachycardia). Other complications may include damage to teeth and lips, swelling in the larynx, sore throat, and hoarseness caused by injury or irritation of the larynx. Other serious risks of general anesthesia include changes in blood pressure or heart rate or rhythm, heart attack, or stroke.

Death or serious illness or injury due to anesthesia is rare and is usually also related to complications from the surgery. Death has been reported to occur in about 1 in 250,000 people receiving general anesthesia, although risks are greater for those people with obesity and other medical conditions.

Many people who are going to have general anesthesia express concern that they will not be completely unconscious but will "wake up" and have some awareness during the surgical procedure. However, awareness during general anesthesia is uncommon but can happen. By agreeing to surgery and anesthesia in this document you are recognizing that while precautions will be taken to avoid awareness during surgery that it could happen.

To decrease the serious and life threatening risks of anesthesia that lead to death, Dr. Rutledge and the physicians and surgeons of The Centers for Laparoscopic Obesity Surgery have chosen a very special kind of anesthetic technique that they believe improves your chances of safely recovering from surgery but may increase the chance of awareness during surgery.

By my initials and comments below I agree to proceed with surgery and anesthesia with the full knowledge of the risk of awareness under this anesthesia and by my specific request that this form of anesthesia be used to improve my overall chances of safety.

If you agree that everything in the above paragraph is correct, check Yes Here: 

Initial the paragraphs above:

Write a description of the previous paragraph and comments (More than two sentences): ______

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Risks of Awareness during General Anesthesia

A person who is given general anesthesia but is not unconscious may be aware of what is happening during the procedure. Awareness during actual surgery is rare but can happen. The frequency of anesthesia awareness has been found in multiple studies to range between 0.1% - 0.2% of adult patients undergoing general anesthesia.

Awareness may be recalled as an implicit memory or explicit memory. With implicit memory, information is retained but not consciously recalled. The person may display symptoms similar to post-traumatic stress disorder, including dreams, flashbacks, anxiety, and sleep disturbances. With explicit memory, the person has spontaneous recall of events that occurred during the procedure, such as sounds and sensations of paralysis or pain. Consultation with a psychiatrist or psychologist may be warranted if a person has signs or symptoms of psychological trauma from awareness during surgery.

By my initials and statements below I agree that I am aware of these risks and complications and specifically request that with full knowledge that these potential problems and complications could occur that we proceed with surgery.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraphs above

Write a description of the previous paragraph and comments (More than two sentences): ________
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The use of Total Intravenous Anesthesia (TIVA).

For the purpose of improving safety and avoiding respiratory complications of anesthesia Dr. Rutledge and the physicians and surgeons of CLOS advocate the use of total intravenous anesthesia (TIVA). The medications you receive will be administered through an IV catheter and you will not receive anesthetic gas. Gas anesthetics, while often good choices, are deemed more dangerous than TIVA in your case.

To try to avoid awareness during surgery Dr. Rutledge and the physicians and surgeons of CLOS follow the Practice Advisory Guidance to Clinicians from the American Society of Anesthesiologists:

The practice advisory acknowledges the reported incidence of intraoperative awareness of one to two cases per thousand patients receiving general anesthesia. We also recognize the significant psychological harm that some patients may experience following an episode of awareness. To address this safety concern Dr. Rutledge and the physicians and surgeons of CLOS treat all patients as high risk for awareness, you are now informed that your anesthetic depth will be monitored using multiple modalities. In all of Dr. Rutledge and the physicians and surgeons of CLOS patients brain function monitoring is used on all patients undergoing general anesthesia (BIS Monitoring.)

Many ASA members (69%) surveyed believes that brain function monitoring (BIS monitoring) is valuable and should be used to help reduce the incidence of awareness in patients at risk.

If I sustain awareness I agree to inform you so that we can provide assessment, reporting and counseling.

Dr. Rutledge and the physicians and surgeons of CLOS believe that all MGB patients are at risk for intraoperative awareness. Risk factors for awareness include:
* Substance use or abuse;
* Patient history of awareness;
* Difficult intubation;
* Cardiac surgery, Cesarean section, trauma and emergency surgery;
* Reduced anesthetic doses in the presence of paralysis;
* Use of muscle relaxants; and
* Total intravenous anesthesia (TIVA) and other anesthesia techniques.

In summary, I know that I have a risk of awareness during surgery (about 1-2/1,000.) The BIS electronic brain monitoring system will be used to help protect against awareness.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above

Write a description of the previous paragraph and comments (More than 2 sentences): __________
______________________________________________________________________________

Ketamine for the Prevention of Post-Operative Pain

I know that between 30 to 70% of patients continue to suffer severe postoperative pain. A variety of causes of inadequate control of post-operative pain have been identified.

Our goal is the delivery of the best possible pain relief for your post-operative recovery. That means our desire is expend our efforts to try to deliver a balance of safety and effectiveness in post-operative pain management. Opioids

Narcotic analgesia (pain medication) is the most commonly used method of postoperative pain management. While narcotics are very effective pain relievers they are also well known as dangerous and sometimes deadly drugs.
Narcotics can cause breathing to slow or even stop and especially in obese patients this risk is magnified. Thus our desire is to take away all of our patients’ pain but the risks of narcotics keep us ever mindful of their potential to harm as well as help our patients.

Recently a new use of an old drug (ketamine) has been shown to decrease patient’s post-operative pain and to decrease the need for the use of narcotics increasing patient safety. The following section is designed to explain more about the use of ketamine for your post-operative pain management.

**Ketamine**

Ketamine is a rapid-acting general anesthetic normal or slightly enhanced skeletal muscle tone, cardiovascular and respiratory stimulation, and occasionally a transient and minimal respiratory depression. The patient's airway is well maintained.

Ketamine has a wide margin of safety; several instances of unintentional administration of overdoses of Ketamine (up to ten times that usually required) have been followed by prolonged but complete recovery.

Ketamine has been studied in over 12,000 operative and diagnostic procedures, involving over 10,000 patients from 105 separate studies. During the course of these studies, Ketamine was administered as the sole agent, as induction for other general agents, or to supplement low-potency agents.

Ketamine has been used successfully in many types of surgery including the anesthesia for a variety of other surgical procedures. In these studies, the anesthesia was rated either “excellent” or “good” by the anesthesiologist and the surgeon at 90% and 93%, respectively.

**Warnings**

Postoperative confusional states may occur during the recovery period. Respiratory depression may occur with over dosage or too rapid a rate of administration of Ketamine, in which case supportive ventilation should be employed.

**Precautions**

Information for Patients: The patients should be cautioned that driving an automobile, operating hazardous machinery or engaging in hazardous activities should not be undertaken for 24 hours or more (depending upon the dosage of Ketamine and consideration of other drugs employed) after anesthesia.

Drug Interactions: Prolonged recovery time may occur if barbiturates and/or narcotics are used concurrently with Ketamine. Ketamine is clinically compatible with the commonly used general and local anesthetic agents.

**Adverse Reactions**

Emergence reactions have occurred in approximately 12 percent of patients. The psychological manifestations vary in severity between pleasant dream-like states, vivid imagery, hallucinations, and emergence delirium. In some cases these states have been accompanied by confusion, excitement, and irrational behavior which a few patients recall as an unpleasant experience. The duration ordinarily is no more than a few hours; in a few cases, however, recurrences have taken place up to 24 hours postoperatively. No residual psychological effects are known to have resulted from use of ketamine.

The incidence of these emergence phenomena is least in the elderly (over 65 years of age) patient. Also, they are less frequent when the drug is given intramuscularly and the incidence is reduced as experience with the drug is gained.

The incidence of psychological manifestations during emergence, particularly dream-like observations and emergence delirium, may be reduced by using lower recommended dosages of ketamine in conjunction with intravenous diazepam during induction and maintenance of anesthesia. Also, these reactions may be reduced if verbal, tactile and visual stimulation of the patient is minimized during the recovery period. This does not preclude the monitoring of vital signs.

Low dose Ketamine is now being used in these cases to supplement anesthesia, support the blood pressure and improve pain relief and decrease the need for narcotics, thus making the recovery safer and less painful.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

**Write a description of the previous paragraph and comments (More than two sentences):** _______

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______________________________________________________________________________

**Risks of Birth Defects:**

Vitamin and mineral deficiencies can put the newborn babies of gastric bypass mothers at special risk of Major Birth Defects.

No pregnancy should occur for the first one to two years after operation.

Gastric Bypass has been shown to cause multiple types of vitamin and mineral deficiencies including: iron, B12, Folate, calcium and many others. Many of these deficiencies have been shown to cause birth defects or are suspected that they could cause birth defects.

We also know that many patients who lose weight feel that they are well after surgery and forget to take their vitamins.

Patients must be certain not to miss any of their vitamins if they decide to go ahead with pregnancy later.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

**Write a description of the previous paragraph and comments (More than two sentences):** _______
Warning to women using Oral Contraceptives (Birth Control Pills): Many women take 'the pill' to prevent pregnancy. Typical failure rates among pill users are as high as 12% to 20% in some surveys. Other factors have been shown to increase the risk of pill failure: smoking, diarrhea and/or vomiting drug interactions, systemic illness, psychological stress, and menstrual disturbances. Therefore birth control pills may not be an effective method after the Mini-Gastric Bypass until those factors have resolved. An unplanned pregnancy can be one of life's most difficult experiences.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Risks of Mini-Gastric Bypass

I also realize that there are particular risks associated with the Mini-Gastric Bypass procedure proposed for me and that these risks include, but are not limited to: Bleeding, Leak, Abscess and serious intra-abdominal infection and Blood Clots all of which can lead to repeated operation admission to the intensive care unit and sometimes death.

I realize that my surgeon plans to perform the operation laparoscopically, and that this approach has special risks including injury to the abdominal contents such as blood vessels, the bowel and other organs.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Follow Up

I recognize that an operation upon my stomach and upper digestive tract is a serious undertaking with known long term risks that my surgeon and The Centers for Laparoscopic Obesity Surgery educational program have described to me including hair loss, serious vitamin and mineral deficiencies and other known and unknown problems. I am committed to fulfilling my surgeon's and The Centers for Laparoscopic Obesity Surgery's instructions for long term follow up. I promise I will make every effort to follow the directions to protect myself from these and other problems associated with the bypass.

I will not leave the area following surgery for 7 days after surgery and until I have been seen in my surgeon's clinic and have been approved for discharge from the area.

I confirm that I will return to my surgeon's clinic at 1, 3 and 6 months following surgery and every year thereafter for evaluation and further education. In extraordinary circumstances in which I cannot reach my surgeon's clinic I will go to my local medical Doctor's clinic and with his/her approval complete that follow up visit with my local medical doctor. In that event I will make certain that my medical doctor forwards copies of my clinic visit to my surgeon. I understand and agree that my surgeon and The Centers for Laparoscopic Obesity Surgery expects me to return to their clinic for follow up and it is only in unusual circumstances that I will miss these appointments.

I promise that I will go to The Centers for Laparoscopic Obesity Surgery's web site at http://clos.net/ff2.htm and complete the "Patient Follow-Up Form" monthly after surgery. As part of my commitment to careful follow up, I promise to alert The Centers for Laparoscopic Obesity Surgery office of any changes in my address, telephone numbers, and email address or health status.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Risk of MGB patients seeing RNY Surgeons

I know that Recently several Roux-en-Y surgeons have written a paper saying that they have seen many Mini-Gastric Bypass patients who were operated on and converted to Roux-en-Y by surgery because of "bile reflux". I know I can see any doctor that I want to. I know some surgeons have concerns about the MGB and have published their feelings on this issue.

I know that if I see a non-MGB surgeon that I may get advice to have surgery. I know that in many cases Dr. Rutledge believes that such surgery might not be necessary and that Dr. Rutledge does not prefer the RNY. I know Dr. Rutledge does not "mind" if I see other Doctors but by seeing Dr. Rutledge first I might get advice that does not include surgery and might be able to avoid another operation. I know that several of Dr. Rutledge's patients
I know that Dr. Rutledge feels that revision of the MGB is relatively easy but that revision of a RNY is a difficult dangerous and deadly procedure and he will usually refuse to revise a RNY surgery because of his fears of patient complications and death. Whatever I decide I know Dr. Rutledge will do all that he can to help and support me as long as I do my part and remain committed to maintaining my agreed upon follow up with my MGB doctor.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Doctor-Patient Relationship:

I know that follow up is critical for safe long-term health after gastric bypass and for adequate maintenance of a Doctor patient relationship. The follow up requirements have been described above and I have agreed to meet these requirements. These requirements are very important for my safety, are not onerous or unreasonable.

I explicitly agree to comply with the clearly stated need to follow the medical advice for follow up after my surgery. For example, if I were to sustain excess weight loss following surgery and not return to clinic to perform my agreed upon follow up that such an action would be a breach of the doctor patient relationship and Dr. Rutledge could in no way be responsible for any untoward or bad outcomes or complications. That is to say I must return to clinic for follow up if Dr. Rutledge is to have any chance of taking care of me.

I have to come back to clinic for follow up for Dr. Rutledge to care for me. I understand that Dr. Rutledge does want to take care of me but that he cannot do it if I do not want to fulfill my part of the bargain. I need to be responsible for follow up for Dr. Rutledge to provide my medical care this bond is the Doctor Patient relationship. I agree to enter into this special bond with Dr. Rutledge and I also agree that if I break it that Dr. Rutledge cannot be held responsible for bad outcomes problems or complications.

I know and agree that in the event that I fail to complete my follow up responsibility then I hereby agree that such actions will terminate my Doctor patient relationship. It is absolutely and unquestionably my responsibility to stay in touch with my doctor after surgery. I know it is important. I know it is a life and death commitment and I agree to stay in touch and complete my follow up.

In the event that I do not comply with the advice and directions of Dr. Rutledge then I agree that Dr. Rutledge would no longer be able to serve as my physician.

I know and agree that noncompliance in meeting the agreed upon follow up requirements prevents my Doctor from providing me adequate care.

Dr. Rutledge has explained to me the critical need for continuous follow up after my surgery. If I decline to follow my Doctor’s advice then we agree such an action would sever our relationship and remove any responsibility my doctor (Dr. Rutledge) would have to me.

I agree that I am aware and agree that the physician-patient relationship depends on mutual rapport. In the event that I no longer follow Dr. Rutledge’s advice and directions then I agree that this will terminate our relationship and any patient care responsibilities. Dr. Rutledge would then no longer be my physician.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Email and Telephone Calls

I know that Dr. Rutledge and the staff welcome my telephone and email communications. But I understand that a telephone call or an email is for the purposes of discussion and informational purposes only. I understand and agree here that follow up requires clinic visit so that Dr. Rutledge can see me and care for me. The information transmitted by email from Dr. Rutledge’s website is not secure. Therefore confidential or sensitive information sent is solely at my discretion. I know that sending email to Dr. Rutledge does not constitute a doctor-patient relationship. I know that a doctor patient relationship can neither be created or maintained by email alone.

I know that my doctor patient relationship requires following up with Dr. Rutledge in person in clinic. I know that Dr. Rutledge cannot offer specific medical advice over the Internet. I know that the information on Dr. Rutledge’s website may or may not be current and may contain errors and omissions.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences):

Follow Up Telephone

I recognize that an operation upon your stomach and upper digestive tract is a serious undertaking with known risks that my surgeon and The Centers for Laparoscopic Obesity Surgery educational program have described to
me. I promise I will stay in the area within two hours of the hospital and provide a telephone number so I can always be contacted:

Emergency Telephone Contact Number: __________________________________________________

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): _______
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Unexpected Outcomes:
I know that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made about the results that may be obtained from this procedure. I am aware that in the practice of medicine, other unexpected problems, risks or complications not discussed may occur. I also understand that during the course of the proposed procedure unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): _______
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Danger of Leaving the Area:
I recognize the serious nature of this Mini-Gastric Bypass surgery. I am well informed about the risk and potential for unforeseen complications and even death. I am aware that I need to stay in the area near the hospital to allow my surgeon to be able to diagnose and treat any unexpected problems or complications. I therefore confirm that I am aware I must stay in the area for at least 7 days so I can be available for treatment and appropriate care. I recognize that other procedures might need to be performed and I confirm that I will remain in daily contact with my surgeon and The Centers for Laparoscopic Obesity Surgery for the first 2 weeks after my surgery.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): _______
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Authorization for Release Medical Information:
I hereby confirm that I freely approve of the release of my medical information for the purposes of education and advocacy of the rights of obese patients and that I have not in any way been coerced into this authorization. I recognize that I can refuse to approve of this use of your personal medical information with no negative impact upon my care or treatment by the surgeons and staff of The Centers for Laparoscopic Obesity Surgery.

I have had the opportunity to consider whether or not to approve this use of my personal information and I state that I have not been the subject of coercion or undue influence to agree to this release of information. I hereby authorize Dr. Robert Rutledge, the surgeons, and staff of The Centers for Laparoscopic Obesity Surgery to use any portions or parts of my medical records and information pertaining to the medical history, mental or physical condition, services rendered, or treatment given for the purposes of education of future patients. I understand that the sole use of this information will be in an attempt to help others. The information supplied is to be used to educate individual patients, Doctors as well as other members of the public including Health Insurance Companies and the News Media. This authorization shall become effective immediately.

I consent and agree that still photographs, motion pictures, or television presentations in the form of either live or video tape may be made of me.

This release gives the CLOS the right to use the above-listed visual material in conjunction with the teaching, instruction, training, information and education of employees, patients, the public, insurance companies and others in the public.

I hereby release the CLOS, Dr. Rutledge and the hospital and I discharge any claim of any nature against them.

If you agree that everything in the above paragraph is correct, check Yes Here: †
Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences): _______
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______________________________________________________________________________

Consent to Procedure and Treatment:
Having read this form and talked with my surgeon, my signature below acknowledges that:
I voluntarily give my authorization and consent to the performance of the Mini-Gastric Bypass procedure described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences): _______

Governing Law:

I clearly and completely agree that this contract between myself, and Dr. Rutledge is governed by the laws of the State of Nevada. I agree that in lieu of proceeding to any court action to mediate any dispute.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences): _______

**Agreement to Binding Arbitration**

Arbitration agreements require that the parties agree to resolve any and all disputes that arise using binding arbitration, rather than in court. I know that binding arbitration involves the submission of any disputes to a neutral party, usually a retired judge, who renders a decision following a hearing. I agree that arbitration will take the place of a trial before a judge or jury. I agree that the arbitration is binding, and there are no grounds for appealing or setting aside the arbitration decision.

I am aware that there are some advantages and disadvantages of binding arbitration. Binding arbitration is less formal and technical than court, can result in quicker resolution of the dispute, waives the right to have any claims decided in court, provides finality, and severely limits appeals and finally provides a private forum for the dispute.

I agree that this contract between myself, Dr. Rutledge and all disagreements will be managed by mandatory, private, binding arbitration. I agree that it is efficient, leads to informed decision making, and sustains a cordial unbiased relationship between patients and their physicians.

I agree that the costs will be shared equally for such mediation. In the event of failed mediation then I agree to proceed to arbitration and I agree that any dispute arising out of the agreement will be decided by neutral arbitration as provided for by the laws of the state of Nevada.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above

Write a description of the previous paragraph and comments (More than two sentences): _______

A Message to Our Patients about Arbitration

The Operative Consent Agreement is an arbitration agreement. By signing this agreement, we (the doctor the patient and the hospital) are agreeing that any dispute arising out of the medical services received is to be resolved in binding arbitration rather than a lawsuit in court.

Medical malpractice insurance rates are skyrocketing. Practicing physicians have two options continue to pay the rapidly escalating charges or try to intervene to decrease the costs of medical liability insurance. Frivolous lawsuits are part of the rise in insurance rates. For example you may have heard this story:

_A woman buys a coffee at McDonald's and drives off with the coffee between her legs. After the coffee spills and scalds her, she sues McDonald's for the coffee being too hot. She wins a $2 million dollar judgment._

The costs and settlements of these and other kinds of lawsuits translate into higher insurance rates. In some cases doctors are performing unnecessary tests and procedures in a kind of "defensive medicine." Numerous doctors have retired because of the rising costs of malpractice insurance.

"There are factors operating, particularly in Nevada, which make it a prime example of the problems physicians, hospitals, insurers and patients are facing nationwide," says Carol Golin, editor of the Medical Liability Monitor, which surveys insurance company issues. In Nevada the number of new lawsuits is reaching record highs and the awards are increasing at unprecedented rates as well.

Experts believe that resolving disputes by arbitration is a good system that addresses many of these issues in ways that are fair for both patients and physicians. A single arbitrator, usually a retired judge, hears the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, the judgment is more often found to be fair and reasonable on review and both parties are spared some of the problems seen in a public jury trial.

Our goal is to provide the highest quality of medical care and to avoid any such dispute. We have priced our medical care fairly and this is based upon our efforts to limit inappropriate legal costs.

If you agree that everything in the above paragraph is correct, check Yes Here: †
AN OVERVIEW OF ARBITRATION

Introduction
Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as various Medical Associations and is a favored method of resolving disputes by the United States Supreme Court. The information included here is provided for your education on some of the basic principles of arbitration.

What is arbitration?
Arbitration is an alternative way of resolving disputes. Instead of disagreements being taken through long and expensive process of court litigation, it is agreed in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, similar to a court proceeding, the arbitrator makes the decision (“award”). The same laws and same measure of damages, which apply in court proceedings, also apply in arbitration.

Does arbitration prevent you from making a claim?
No. Arbitration allows for a rapid and more straightforward approach to deliberation on issues that may arise and to hear and decide any claims.

Does arbitration prevent you from obtaining a financial award?
No, not at all. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim, he will determine a damage award. The United States Supreme Court has held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of your choice?
Yes. All parties to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?
By signing the arbitration agreement, you agree to oblige yourself and others on your behalf to use binding arbitration.

What does arbitration cost?
Arbitration is usually less expensive than court actions. The arbitrator’s fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?
The purpose of arbitration is to avoid the expenses, delays, emotional public nature and inconvenience of a court trial. Ms. Brown was made aware that in rare circumstances, arbitration awards may be reviewed, and potentially reversed (“vacated”) by a court.

If you agree that everything in the above paragraph is correct, check Yes Here: †

Initial the paragraph above
Write a description of the previous paragraph and comments (More than two sentences):

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