

☐ Alfred ☐ Sandringham ☐ Caulfield

## BARIATRIC CLINIC SCREENING QUESTIONNAIRE

Family Name*				Given Name*			
Date of Birth*		Age		Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other
Address							

\*mandatory fields

Thank you for completing this questionnaire, to support allocating an appointment

Return completed questionnaire to: F 9076 0113 E [bariatric.program@alfred.org.au](mailto:bariatric.program@alfred.org.au)

(Save questionnaire to your computer to complete electronically)

<b>Patient's age:</b>	*There is limited evidence on the effectiveness of bariatric surgery in people aged under 18 years and over 65 years		Years
<b>Patient's BMI (weight / height<sup>2</sup>):</b>	*Suitable candidates for bariatric surgery are those with a BMI greater than 40, or greater than 35 with medically important obesity-related co morbid conditions that could be improved by weight loss		BMI
<b>Previous attempts to lose weight:</b>			
*All appropriate non-surgical measures should have been tried but failed to achieve or maintain adequate, clinically beneficial weight loss			
<input type="checkbox"/> Diet and exercise program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Dietitian consultation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Participation in formalised weight loss program eg Weight Watchers, Jenny Craig, Lite'n'Easy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Meal replacement program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Previous Bariatric Surgery – Barium Swallow & Gastroscopy required prior to referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Obesity-related comorbid conditions:</b>			
*Priority will be given to patients with significant chronic diseases that are currently not well treated but which are known to respond well to weight loss			
<input type="checkbox"/> Hypertension requiring medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Type 2 diabetes mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Obstructive sleep apnoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Pulmonary hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Obesity hypoventilation syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Non-alcoholic steatohepatitis (fatty liver)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Polycystic ovary syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other			
<b>Surgical risk:</b>			
*There may be medical contraindications to bariatric surgery			
<input type="checkbox"/> Active cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Unstable heart or lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Advanced liver disease with portal hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Uncontrolled obstructive sleep apnoea with pulmonary hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Serious blood or autoimmune disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Provide details:			
<b>Mental health and cognitive status:</b>			
*Patients must be able to give fully informed consent and commit to the program			
<input type="checkbox"/> Active psychosis or unstable psychiatric disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Severe untreated depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Current alcohol dependence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Current illicit substance use disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Cognitive or behavioural disorders affecting decision-making	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other			(Office use: ESS Score: _____)
<b>Referrer Details</b>		Date of Referral	Provider No
Name	Address		
Telephone	Email		
Fax	Copies to		

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## BARIATRIC CLINIC SCREENING QUESTIONNAIRE

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### EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations.

Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS).

Each item is rated from 0 to 3: with 0 meaning you would never *doze or fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING				
Sitting and Reading	0	1	2	3	
Watching Television	0	1	2	3	
Sitting inactive in a public place (theatre/meeting)	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (with no alcohol)	0	1	2	3	
In a car, while stopped in traffic	0	1	2	3	
	TOTAL SCORE				

Note: If the Epworth Sleepiness Score is 15 or greater, consider referral for [Respiratory Assessment / Sleep Clinic](#) or a Sleep Study [Respiratory Medicine and Sleep Disorder Specialist Clinic Referral Guidelines](#)

Dr Name		Date	
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