Baylor Scott & White
CENTER FOR MEDICAL & SURGICAL
WEIGHT LOSS MANAGEMENT

Baylor Scott and White Center for Medical and Surgical Weight Loss Managment

Treatment Agreement – Weight Management Program for Dr. Sully Drotar

I understand this is a comprehensive program designed to help me reach my weight loss goals and health outcomes. The program has a multidisciplinary approach that includes doctors, physician assistants, nurse practitioners, registered dietitians, and other team members who specialize in obesity and metabolic diseases. The team provides education and guidance towards making long term lifestyle changes. I understand the team is dedicated to providing me with a personalized organized approach to achieve improved health and my weight loss goals.

I understand that to participate in the program, I must attend my scheduled visits. These usually consist of at least monthly visits with the provider (sometimes more frequently). I understand the Baylor Scott and White No Show and Late Cancellation Policy, and I risk dismissal from the program if I no show or cancel within 24 hours of my appointment more than three (3) times. I understand that every 3rd or 4th visit (per provider discretion) MUST be in person and cannot continue to participate on a virtual visit basis only unless otherwise discussed or on maintenance plan. I understand that I may be terminated from the program if I do not follow up as recommended.

By signing this treatment agreement, I am choosing to enroll in this program and agree to participate in my care.

_____

Patient Signature

_____

Patient Printed Name

_____

Date

Baylor Scott & White
HEALTH

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name			**Today's Date**			
Instructions *Please answer the questions below, rating yourself on a scale of 1 through 5 on each of the criteria as shown to the right. As you answer each question in a way that best describes how you have felt and conducted yourself in the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.*		1 Never	2 Rarely	3 Sometime	4 Often	5 Always
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking to much when you are in social situations?						
16. When you are in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
Total Score: Inattention, Subscale A						
Total Score: Hyperactivity, Subscale B						

Patient Name: _____ Date: _____

Patient Signature: _____

FOR FEMALES PATIENTS ONLY

What type of contraception are you currently using?

Please mark all that apply to you:

___ Condoms (male or female)

___ Spermicide

___ Oral birth control

___ Birth control patch

___ Nuvaring

___ DepoProvera (birth control injection every 3 months)

___ Nexplanon

___ IUD

___ Tubal ligation

___ Partner has a vasectomy

___ Hysterectomy (surgical absence of the uterus)

___ Oophorectomy (surgical absence of the ovaries)

___ Postmenopausal

___ Same sex relationship

___ Not currently sexually active

Patient Name: _____

Patient DOB: _____

BEALES DIAGNOSTIC CRITERIA

PLEASE CHECK ALL THAT APPLY TO YOU:

PRIMARY FEATURES:

___ Childhood Obesity

___Learning Disability

___Male Hypogonadism

___Kidney Abnormalities

___Visual Defects (ie Rod Cone Dystrophy)

___Polydactyly (ie extra fingers or toes)

SECONDARY FEATURES:

___Diabetes Mellitus

___Excessive Thirst, Excessive Urination, or Diagnosis of Nephrogenic Diabetes Insipidus

___Strabismus, Cataracts, or Astigmatism

___Dental Crowding, Hypodontia, Small Roots, or High Arched Palate

___Speech Disorder or Delay

___Developmental Delay

___Brachydactyly (short fingers or toes) or Syndactyly (webbed toes/feet or fingers/hands)

___Ataxia (loss of muscle control), Poor Coordination, or Imbalance

___Spasticity

___Left Ventricular Hypertrophy, Congenital Heart Disease

___Hepatic Fibrosis

Binge Eating Disorder Screener (BEDS-7) Symptom Self-Assessment

For use with adults

This tool is intended for screening use only. It should not be used as a diagnostic tool.

The following questions ask about your eating patterns and behaviours within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	YES	NO

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	YES	NO

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

Please share this screener with your healthcare team.

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Patient Name

Patient Signature

Date:

MEDICATION CONTRADICTIONS

Please circle if you have any of the following:

Heart Disease

Atrial Fibrillation or Abnormal Heart Rhythm

Uncontrolled Hypertension (high blood pressure)

Personal or Family History of Medullary Thyroid Cancer

Personal or Family History of Men II Syndrome

Pancreatitis

Glaucoma

Seizures

Hyperthyroidism

Kidney Stones (calcium oxalate)

Frequent or Regular Use of Pain Medications

Gallstones

Uncontrolled Anxiety or Bipolar Disorder

Use Tobacco Products

Drink more than 2 Alcoholic beverages per day

Illicit Substance Use

Currently Pregnant

Currently Nursing

MAO Inhibitor use within the last 14 days

Tamoxifen use

Digoxin use

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

OSMI
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Name _____
Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

NovoPsych

Perceived Stress Scale (PSS-10)

Instructions:

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

In the last month, how often have you...

		Never	Almost Never	Sometimes	Fairly Often	Very Often
1	been upset because of something that happened unexpectedly?	0	1	2	3	4
2	felt that you were unable to control the important things in your life?	0	1	2	3	4
3	felt nervous and "stressed"?	0	1	2	3	4
4	felt confident about your ability to handle your personal problems?	4	3	2	1	0
5	felt that things were going your way?	4	3	2	1	0
6	found that you could not cope with all the things that you had to do?	0	1	2	3	4
7	been able to control irritations in your life?	4	3	2	1	0
8	felt that you were on top of things?	4	3	2	1	0
9	been angered because of things that were outside of your control?	0	1	2	3	4
10	felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Developer Reference:

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan & S. Oskamp (Eds.), The social psychology of health: Claremont Symposium on applied social psychology. Newbury Park, CA: Sage.

Administer Now

Consent Form for Compounded Anti-Obesity & Diabetes Medications

This document is intended to serve as confirmation of informed consent for compounded Glucagon-like Peptide-1 injections (semaglutide or tirzepatide), which are prescription medications used for the intention to treat obesity (medical weight loss) and or diabetes.

Do NOT take this medication if you:

- Have personal or family history of Medullary Thyroid Carcinoma (a rare form of Thyroid Cancer)
- Have multiple Endocrine Neoplasia Syndrome Type 2 (A or B)
- Are pregnant, plan to become pregnant in the next 6 months, or are breastfeeding
- Are allergic to semaglutide (Ozempic, Wegovy or Rybelsus), tirzepatide (Mounjaro or Zepbound), BPC-157 or any other GLP1 (dulaglatide, exenatide, liraglutide also known as branded Trulicity, Byetta, Victoza/Saxenda respectively)

Possible side effects include, but are not limited to:

Nausea, vomiting, diarrhea, constipation, abdominal pain or bloating, dyspepsia, gastroesophageal reflux disease, belching, flatulence, gastroenteritis, dizziness, headache, fatigue, hypoglycemia, hair loss, injection site reactions (itching or burning at the site of administration with or without thickening of the skin)

A serious allergic reaction to this medication is rare. Seek medical attention if you experience symptoms such as rash, itching or swelling (especially of the throat, tongue or mouth), severe dizziness, severe abdominal pain, unrelenting vomiting or trouble breathing

Directions for use:

- I understand this medication must be self-injected in the subcutaneous tissue (abdomen, upper inner thigh, flank area or the back of the arm) once per week
- I understand this medication must be kept refrigerated and expired after 28 days after puncture
- I will notify my provider if I experience side effects or if I am having trouble with administration
- I will not share this medication (or needles) with other and agree to dispose of the needles I use safely

I have informed my provider of all medical conditions, any known allergies to drugs or other substances, and any past adverse reactions that I've experienced. I have informed my provider of all medications and supplements that I am currently taking. I understand this prescription comes from a compounding pharmacy and is not FDA approved. I have been informed that the manufacturing facility is FDA monitored and the medication is third party tested. I am aware of the possible side effects. I understand this medication could be harmful if taken inappropriately and should be used only as prescribed. I acknowledge that no guarantees have been made to me concerning my results.

I certify that I have read the contents of this form in its entirety. I have had the opportunity to ask questions and have had my questions answered to my satisfaction. I fully understand the contents of this form and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks involved.

Patient Name (please print): _____

Signature: _____

Date: _____