

# PACIFIC | NUTRITION & WELLNESS

Name of Patient: \_\_\_\_\_

Place of surgery: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Director Notes

Type of band:                      Allergan/Inamed                      Realize                      Other: \_\_\_\_\_

Size of band with description (ie APS or Vanguard) \_\_\_\_\_

History of complications with band (if any)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fill History (you should provide chart notes from your previous fill center)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weight loss history with the band:

Pre surgical weight was \_\_\_\_\_ and then....

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for seeking care at Pacific Nutrition and Wellness: (please include your goals)

---

---

---

---

---

---

---

Are you willing to take full financial responsibility for any problem that can occur with your band and band fills. Yes No (explain)