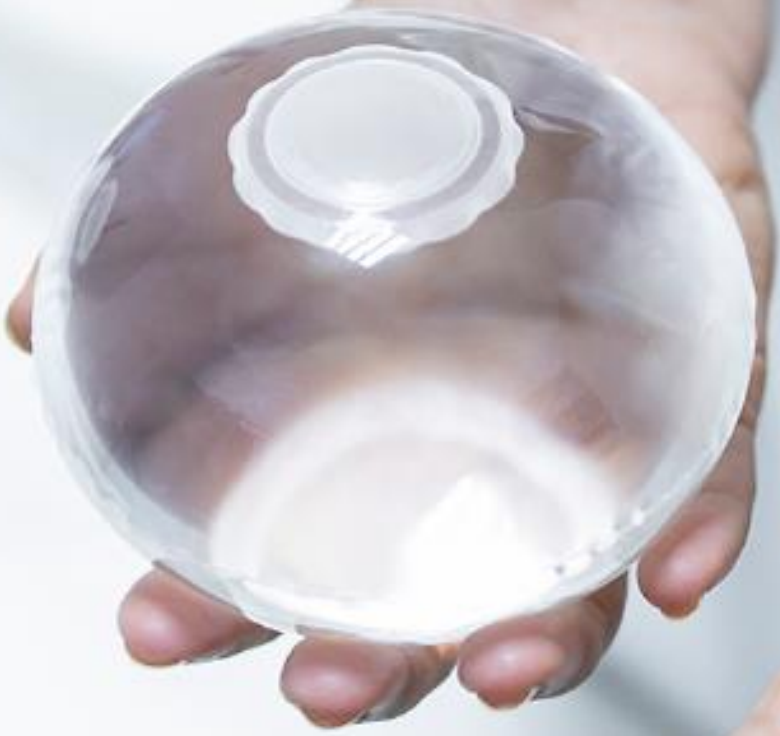
NZGS
General Surgery & Medical

Welcome to the

Allurion
PROGRAM



- No surgery
- No endoscopy
- No anaesthesia

NZGS General Surgery & Medical
14 Rutene Rd • Gisborne 4010 • New Zealand
Phone 06 868 9595 • Fax 06 868 8308
admin@nzgsmedical.co.nz • ww.nzgeneralsurgery.co.nz

Patient Information

Please complete and return to NZ General Surgery and Medical, 14 Rutene Road, Gisborne or admin@nzgsmedical.co.nz as soon as possible or at least 14 days before treatment date. You will be contacted the week before your treatment by a nurse for a pre-assessment.

Personal Information

Surname:		First Name:
Preferred Name:		NHI:
Date Of Birth:	Age:	Gender:
Home Address:		
Postal Address:		
Email:		
Do you consent to your information/clinic letters/test result being sent to the email provided? **Yes** ☐ **No** ☐		
Home Telephone:	Mobile:	Work:
Occupation:		Ethnicity:
Next of Kin/Emergency Contact Person:		Relationship:
Telephone:		Mobile:
General Practitioner:		Medical Centre:
Pharmacy:		

What Allurion Program are you interested in? **Gold** ☐ **Silver** ☐

How did you hear about us? _____

Where did you hear about the Allurion Balloon? _____

History of difficulties and/or complications losing weight (Diets, surgeries, exercise etc..)

_____

_____

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Health Questionnaire

It is important that you answer all questions as accurately as possible. All Information is sought to minimise your risk and will be retained as part of your confidential report

Do you suffer from any of the following?

CARDIAC (HEART)

Chest pain/Angina	No ☐	Yes ☐
Previous Rheumatic Fever	No ☐	Yes ☐
Previous Heart Attack	No ☐	Yes ☐
Cardio Myopathy	No ☐	Yes ☐
Heart Failure	No ☐	Yes ☐

PULMONARY (LUNGS)

Shortness of breath	No ☐	Yes ☐
Chronic cough	No ☐	Yes ☐
COPD/Emphysema	No ☐	Yes ☐
Sleep apnea	No ☐	Yes ☐
Cystic fibrosis	No ☐	Yes ☐

GASTROINTESTINAL

Change in bowel habit	No ☐	Yes ☐
Blood in stool	No ☐	Yes ☐
Gallbladder Stones	No ☐	Yes ☐
Liver/Cirrhosis	No ☐	Yes ☐
Hepatic insufficiency	No ☐	Yes ☐
Inflammatory bowel Disease	No ☐	Yes ☐
Ulcerative colitis	No ☐	Yes ☐
Crohn's Disease	No ☐	Yes ☐
Gastric or duodenal varices	No ☐	Yes ☐
Gastro oesophageal reflux	No ☐	Yes ☐
Gastric ulceration	No ☐	Yes ☐
Duodenal ulceration	No ☐	Yes ☐
Benign or malignant tumour	No ☐	Yes ☐
Severe gastroparesis	No ☐	Yes ☐
Hepatitis A-B-C	No ☐	Yes ☐
Perforated appendicitis	No ☐	Yes ☐

ENDOCRINILOGY

Type 1 Diabetes	No ☐	Yes ☐
Type 2 Diabetes	No ☐	Yes ☐
Thyroid trouble	No ☐	Yes ☐
Venereal disease	No ☐	Yes ☐
HIV positive	No ☐	Yes ☐
Pancreatitis	No ☐	Yes ☐

PSYCHIATRIC

Mental Illness	No ☐	Yes ☐
Depression	No ☐	Yes ☐
Anxiety	No ☐	Yes ☐
Panic Attacks	No ☐	Yes ☐
Alcohol or drug addiction	No ☐	Yes ☐

If you answered "Yes" to any of the above, how do you address or manage these conditions?

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PREVIOUS SURGERIES

Diagnostic laparoscopy	No ☐	Yes ☐
Laparoscopic appendectomy	No ☐	Yes ☐
Open appendectomy	No ☐	Yes ☐
Cholecystectomy	No ☐	Yes ☐
Gastric surgery	No ☐	Yes ☐
Oesophageal surgery	No ☐	Yes ☐
Laparoscopic band ligation	No ☐	Yes ☐
Anti-reflux surgery	No ☐	Yes ☐
Bariatric Surgery	No ☐	Yes ☐
Emergency Surgery, Trauma, Caesarean sections	No ☐	Yes ☐

How many C-Sections? ☐

When? / /

OESOPHAGUS

Achalasia	No ☐	Yes ☐
Scleroderma	No ☐	Yes ☐
Diffuse oesophageal spasm	No ☐	Yes ☐
Stricture	No ☐	Yes ☐
Web	No ☐	Yes ☐
Diverticulum	No ☐	Yes ☐
Large hiatal hernia	No ☐	Yes ☐
Oesophagitis/ Barrett's	No ☐	Yes ☐
Oesophageal varices	No ☐	Yes ☐
Corkscrew Oesophagus	No ☐	Yes ☐

Height: ☐

Weight: ☐

BMI: ☐

OTHER

Cancer?	No ☐	Yes ☐
Autoimmune disorder	No ☐	Yes ☐
Previous gastric balloon	No ☐	Yes ☐

If yes when? / /

Do you Smoke? **No ☐ Yes ☐**

If yes how many a Day?

Do you drink alcohol? **No ☐ Yes ☐**

If yes how much? ☐

How often? ☐

ARE YOU

Taking anticoagulants?	No ☐	Yes ☐
Immunocompromised?	No ☐	Yes ☐
Pregnant?	No ☐	Yes ☐

ALLERGIES

Medication RUSH	**No ☐**	**Yes ☐**
Polyurethane or Silicone	**No ☐**	**Yes ☐**

Other:_____

If you have answered "Yes" to any of the above, please specify in the space below:

☐

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Success with the Allurion programme requires a willingness to engage, changing your lifestyle with physical activity, engagement with the clinician, dietician programmes, pre and post placement. This will include dietary coaching, regular use of the Allurion scale and fitness device.

Are you willing to commit and adhere to wanting to change your eating habits and continue to lose weight after you pass the Allurion balloon? **No** ☐ **Yes** ☐

Are you willing to take prescribed proton pump inhibitor (Omeprazole) medications in preparation for and/or during device residence? **No** ☐ **Yes** ☐

Are you willing to hydrate (at least 2 litres of water) the day before the procedure? **No** ☐ **Yes** ☐

Are you willing to take prescribed antiemetic medications (Ondansetron/Scopoderm) in preparation for and/or during device residence? **No** ☐ **Yes** ☐

Have you been or previously been diagnosed bulimia, binge eating, compulsive overeating, or similar eating-related psychological disorders? **No** ☐ **Yes** ☐

Are you able to discontinue use of non-steroidal anti- inflammatory drugs (Ibuprofen, Aspirin, Diclofenac) or other gastric irritants during the device period? **No** ☐ **Yes** ☐

By selecting "Yes" you acknowledge that the balloon will only qualify for a free replacement if it is confirmed to be faulty within the 90 day warranty period. **No** ☐ **Yes** ☐

By selecting "Yes," you agree to bear the additional costs associated with the balloon procedure, including X-ray expenses, which will be payable by the patient. **No** ☐ **Yes** ☐

If you have answered "No" to any of the above, please specify in the space below:

Have you suffered from any other medical condition/problem not listed in the questionnaire above? (Significant past illness, disease, involving complications and/or trauma) **No** ☐ **Yes** ☐

Approx. Date	Medical Condition

Please list any previous surgeries: Involving any complications (if applicable)

Surgery	Approx. Date	Complication

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What medication/s are you taking? (Including over the counter drugs, vitamins/herbal or contraceptive)

Medication/ Remedies/Supplements	Dose	Frequency

DECLARATION

I hereby confirm that all the information provided above is accurate to the best of my knowledge. Furthermore, I acknowledge and agree that in the event of any changes to the aforementioned information prior to my procedure, I will promptly notify NZ General Surgery and Medical. This includes notifying them of any occurrences such as common colds or general unwellness, as it may or may not impact the originally agreed upon date of my procedure.

Moreover, in the event that I, as the patient, decide to have the balloon removed, I understand that I will be responsible for all associated expenses. I acknowledge that such removal will not qualify me for any refund or reimbursement.

Date of Procedure:

Signed:	Date: / /

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