A Division of Contra Costa Health Services

BARIATRIC SURGERY MENTAL HEALTH ASSESSMENT

CCHP does not require a mental health evaluation prior to bariatric surgery. However, many of our surgeons operate at Bariatric Surgery Centers of Excellence. These Centers of Excellence require a mental health evaluation by a licensed mental health professional prior to surgery. Acceptable providers include psychiatrists, psychologists, licensed marriage family therapists, and social workers. Please reference the Bariatric Surgery Centers of Excellence Guidelines for further information. Please work with the surgeon you are referring to in order to figure out what documentation they prefer. Below is a form that CCHP understands, if filled out by the mental health professional, and provided to the surgeon, meets the requirements. However, this form is not required. Please contact the surgeon you are referring to if you have specific questions.
If you need to request that CCHP authorize a mental health evaluation, please use the "Mental Health Evaluation Prior to Bariatric Surgery" referral order in ccLink or the provider portal to make that request.

TO BE COMPLETED BY MENTAL HEALTH PROVIDER:

I. PERSONAL HISTORY

Place of birth: ______________________ Current city of residence: ______________________

Highest level of education: ____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is the patient's current home situation and associated family dynamics? ___________________

____

II. WEIGHT MANAGEMENT

How long has the patient been obese? ____

Please discuss the patient's perceptions of successes and failures with previous weight loss attempts:____

____

III. MENTAL HEALTH HISTORY

Please list the sources and level of stress the patient is experiencing: __________________________

____

What are the patient's main sources of support (family or other)? ____________________________

	YES	NO
Patient has abilities/strategies to cope with stress without using food.	☐	☐
Is using or has used tobacco, alcohol, or recreational drugs.	☐	☐
History of substance abuse.	☐	☐
History of physical, emotional, or sexual abuse.	☐	☐
History of emotional eating issues.	☐	☐

Comments: ____

Please list any depression, anxiety, suicidal tendencies, or eating disorders experienced by the patient and the treatment sought: ____

____

Please specify any current or recent psychotropic medications, psychotherapy, or professional services sought: ____

____

Please comment if the MMPI-2 (Minnesota Multiphasic Personality Inventory) or other testing has revealed any untreated or incompletely treated condition that may interfere with successful bariatric surgery: ____

____

IV. COMPLIANCE WITH TREATMENT REGIMEN

Please include details about the patient's history of compliance with recommended medical/psychological treatments: ____

____

	YES	NO
Patient is likely to be compliant with required medical follow-up after surgery.	☐	☐
Patient understands that noncompliance puts him/her at risk of complications and poor weight loss.	☐	☐
Patient is likely to understand and be compliant with specific diet, exercise, and vitamin regimen after surgery.	☐	☐

Comments: ____

V. SURGICAL PROCEDURE

	YES	NO
Patient comprehends risks and benefits of surgical procedure.	☐	☐
Patient has a realistic expectation of body image and lifestyle changes.	☐	☐
Patient is capable of giving informed consent.	☐	☐

Comments: ____

VI. RECOMMENDATIONS

	YES	NO
Did you identify any mental health contraindications to surgery?	☐	☐
Do you recommend one-on-one counseling with a qualified mental health professional prior to surgery?	☐	☐
Do you recommend evaluation (or ongoing monitoring) of the patient's need for psychotropic medications?	☐	☐
Does the patient need substance abuse treatment prior to surgery?	☐	☐

If YES, please comment:____

____

PROVIDER (PRINT NAME): ____

SIGNATURE: ______________________________ **DATE:** ________________