OSF SURGICAL WEIGHT LOSS CENTER OF EXCELLENCE
DEPARTMENT OF PHARMACEUTICAL CARE SERVICES
(309) 655-6805

ROUX-EN-Y (GASTRIC BYPASS) RECOMMENDATION FORM

Patient Name: _____ Date of Birth: _____ Date of Surgery: _____

Dear Dr: _____

Please see the fax cover sheet included for instructions on the following recommendations. Please see included vitamin supplements recommendations per OSF Surgical Weight Loss Center of Excellence pre- and post-operatively.

(I) Extended Release Dosage Forms: (avoid post-op indefinitely due to absorption issues)

Current Medication	*Suggested Conversion*

(II) Medications to consider discontinuing/holding: (see each medication for specifics on timing of change)

Hold/Discontinue	*Rationale*	*Recommendations*

(III) Medications that may require increased monitoring/dose adjustment:

Adjust/Monitor	*Monitoring Parameters*

(IV) Miscellaneous Comments/Recommendations: Patients should crush tablets/open capsules for the first 6 weeks following surgery to decrease the pressure at the surgical site and aid in healing.

-Crush the following:

-Open the following:

Thank you for your attention to this evaluation. Please call 655-6805 and leave a message regarding any questions or concerns. Calls will be returned during regular business hours Monday – Friday from 8am-3pm.

Sincerely,