Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ / 20_ _ Initials: _____

For office use only.

Gastric Sleeve (GS) – Version 07/31/2007 FORMV

Patient ID __ __ __ - __ __ __ - __ __ **ID**

Form Completion Date __ __ / __ __ / 20 __ __
GSDAT mm dd yy

Certification number: __ __ __ __ __ **CERT**

Date of Surgery __ __ / __ __ / 20 __ __
SURGDAT mm dd yy

1. *SLEEVE STAPLING MEASUREMENTS:*		*How was it measured?* String (1)	Ruler (2)	Grasper (3)
1.1 Total length of staple line:	**STPLINE** (cm) →	**SLINEM**		
1.2 Bougie/tube size:	**BOUGIE** (Fr)	n/a	n/a	n/a
1.3 Distance from the Pylorus to the sleeve staple line:	**PYLORUS** (cm) →	**PYLORUSM**		

2. Type of stapling line: **TYPELINE** ☐ 1. Partitioned ☐ 2. Divided

3. Record the staple height for the sleeve: (check "no" or "yes" for each)

No	Yes		No	Yes	
☐	☐	2.5 millimeters **SLE25**	☐	☐	4.5 millimeters **SLE45**
☐	☐	3.5 millimeters **SLE35**	☐	☐	Other **SLEO** (specify: **SLES** millimeters)

4. Identify the manufacturer of the stapling device: **STPLMFG** ☐ 1. U.S. Surgical® ☐ 2. Ethicon® ☐ 3. Other (Specify: **STPLMFGS**__)

5. Was a method used to test anastomoses? ☐ 0. No ☐ 1. Yes
TESTANA

5. 1 If yes, check "no" or "yes" to each item in the box:

No	Yes		Results 1. Neg. 2. Pos.	*If any of the tests were positive, was an action taken?* **ACTION**	No	Yes	Action *check 'no" or "yes" for each item.*
☐	☐	1. Air by Tube **AIR** →	**RESAIR**	☐ 0. No ☐ 1. Yes →	☐	☐	Suture repair **ACTSUT**
☐	☐	2. Air by endoscopy* → **EDG**	**RESEGD**		☐	☐	Glue **ACTGLU**
☐	☐	3. Methylene Blue → **MBLU**	**RESMBLU**		☐	☐	Complete anastomosis redo **ACTREDO**

**NOTE: Air by Endoscopy should only be checked if it was used to test the integrity of the anastomoses.*

6. Was reinforcement used? **REINF** ☐ 0. No ☐ 1. Yes
If yes, specify by checking "no" or "yes" to each.

	No	Yes		No	Yes		No	Yes		No	Yes	
6.1 Specify:	☐	☐	Buttress **RBUTT**	☐	☐	Sealant **RSEAL**	☐	☐	Suture **RSUTU**	☐	☐	Other **ROTH** (specify:**ROTHS**)

7. Was banding or a ring used? **BREINF** ☐ 0. No ☐ 1. Yes
If yes,

7.1 Specify the type of pouch reinforcement:
☐ 1. Siliastic ring **BREINFT** ☐ 3. Synthetic mesh
☐ 2. Patient's fascia ☐ 4. Other (specify: **BREINFS**)

8. Were the nerves of the laterjet seen? □ 0. No □ 1. Yes **LATERJET**

9 Were the nerves of the laterjet cut? **NERVECUT** □ 0. No □ 1. Yes →

□ 1. Partially cut
□ 2. Completely cut **NERVPCUT**

10. On a scale of 1 to 10, with 1 being "easy" and 10 being "very difficult," circle the level of difficulty in performing the surgical procedure from start to finish: **DIFLEV**

Easy Very difficult

1 2 3 4 5 6 7 8 9 10

11. Was there difficulty due to intra-abdominal fat distribution? **DIFFAT** □ 0. No □ 1. Yes

12. Was there difficulty due to thick abdominal wall? **DIFABD** □ 0. No □ 1. Yes

13. Was there difficulty due to limited exposure due to enlarged/fatty liver? **DIFLIV** □ 0. No □ 1. Yes

14. Was there difficulty due to adhesion from previous surgery? **DIFSUR** □ 0. No □ 1. Yes