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Indications for Sacral Nerve Stimulator Implant (InterStim)

Patient Name: _____ DOB: _____

Urinary Incontinence	Fecal Incontinence
SECTION 1: Required	**SECTION 1: Required**
Failure or Intolerance of conventional therapy (refractory to): ☐ Behavioral _____ ☐ Pharmacologic _____ ☐ Surgical corrective therapy _____	**Failure or Intolerance of conventional therapy** ☐ Dietary Modification ☐ Addition of bulking and pharmacologic treatment
SECTION 2: Required	**SECTION 2: Required**
Exclusion to procedure – if yes to any, Stop ☐ None ☐ Stress Incontinence ☐ Cortical Lesion ☐ S2−S5 nerve root injury ☐ Multiple Sclerosis ☐ Metastatic Carcinoma causing epidural spinal cord ☐ Compression ☐ Myelomeningiocele with open bladder neck ☐ Diabetes Mellitus with peripheral nerve involvement ☐ Other neurological disease ☐ Urinary Obstruction ☐ Spinal Cord Lesion ☐ Hemi−Cauda equina	**Exclusion to procedure – if yes to any, Stop** ☐ None ☐ Congenital anorectal malformation ☐ Defects of the external anal sphincter over 60 degrees ☐ Visible sequelae of pelvic radiation ☐ Peripheral neuropathy ☐ Complete spinal cord injury ☐ Active anal abscesses and fistulae ☐ Other neurological condition
	SECTION 3: Required
	☐ Chronic fecal incontinence > 2 episodes/week X > 6 months ☐ Chronic fecal incontinence > 2 episodes/week X 12 months After vaginal childbirth
SECTION 3: Required for Stage 2	**SECTION 4: Required**
Percutaneous Test Stimulation. Improvement percentage Trial Date(s):_____ ☐ 50% or greater improvement through Test Stimulation ☐ Improvement validated by review and analysis of PRE and POST test Stimulation Patient Voiding Diaries	**Percutaneous Test Stimulation. Sustained improvement percentage** Trial Date(s):_____ ☐ 50% or greater more than 1 week sustained improvement in symptoms

The patient and the treating physicians have concluded that the patient has exhausted all conservative measures at this time and now will benefit from Sacral Nerve Stimulator Implant (InterStim). This treatment is necessary for patient to achieve a significantly improved quality of life by significant reduction in overactive bladder symptoms and/or significantly improved bowel control.

Implant Vendor ☐ Medtronic
Reason for Choice: ☐ Demonstrated positive patient Outcomes ☐ Familiarity with products
☐ Other: _____

☐ The patient is an appropriate surgical candidate for implantation with anesthesia

Date: _____ **Time:** _____ **Provider Name:** _____

Provider Signature: _____

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SUBMIT