Henry Mayo Newhall Hospital

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Indications for Spinal Surgery

Rev. 01/04/2023

Patient's Name: ____ DOB:______________________

Symptoms/Complaints

1. **The patient has been complaining of:** ❑ Upper Extremity pain ❑ Right ❑ Left
   Duration: ______months ❑ Lower Extremity pain ❑ Right ❑ Left
   ❑ Lower Back pain ❑ Upper Back pain

2. **The patient's complaints include:**
   ❑ Mild pain ❑ Moderate pain ❑ Severe pain ❑ Excruciating pain
   Present: ❑ Daily ❑ Continuously ❑ Intermittently ❑ Occasionally ❑ Nightly

3. **Complaints also include difficulty with:**
   ❑ Walking ❑ Climbing stairs ❑ Inability to perform Activities of Daily Living

Physical Examination noted the following:

❑ Neurological symptoms to include radiculopathy pain; numbness and tingling
❑ Upper extremity weakness ❑ Lower extremity weakness
❑ Modification to ADLs (Activities of Daily Living)
❑ Pain scale rating of ______/10
❑ Pain elicited with all activity
❑ Difficult or impossible ambulation

Conservative Measures:

1. **The patient has been treated by many conservative modalities and treatment which have not improved the condition of this patient. The conservative management includes:**
   ❑ Non–Steroidal Anti–Inflammatory Medications
   ❑ Steroid Anti–Inflammatory Medications
   ❑ Epidural Steroidal Injections
   ❑ Facet Injections
   ❑ Pain Management Intervention to include medication management via analgesics and other prescribed therapeutic medications
   ❑ Dietary Modifications and Weight Loss

2. **These conservative measures provided:**
   ❑ No relief
   ❑ Minimal Relief
   ❑ Some relief but failed to provided adequate relief of symptoms in support of function and quality of life.
   ❑ Conservative measures contraindicated because ____.

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Patient's Name: ______________________________ DOB: ____________________

Physical Therapy

❑ Has been prescribed ❑ Has not been prescribed ❑ Patient refused
❑ Was contraindicated due to medical issues or disease severity.

Attempts to strengthen the muscles, ligaments and tendons supporting the back has been tried for______months and did not provide adequate results to diminish the pain and improve functional ability.

Occupational Therapy

❑ Has been prescribed ❑ Has not been prescribed ❑ Patient refused
❑ Was contraindicated due to medical issues or disease severity.

Attempts to improve activities of daily living has been tried for _______months and did not provide adequate results to diminsh the pain and improve functional ability.

Assistive Devices

1. **To take the load off the back and to improve functional ability, the patient has been tried on assisting devices including:** ❑ Cane ❑ Walker ❑ Crutches ❑ Bracing
2. **They provided:** ❑ No relied ❑ Minimal relief ❑ Some relief and symptom reduction

Diagnostic Testing Completed:

❑ MRI (Magnetic Resonance Imaging)
Result: ____
❑ Radiographs
Result: ____
❑ Other: ____
Result: ____

The patient and the treating physicians have concluded that the patient has exhausted all conservative measures at this time and now will benefit from Spinal Surgery. This treatment is necessary for the patient to return to a functional and pain manageable condition.

Procedure: ❑ Microdiscectomy ❑ Laminectomy ❑ Foraminotomy ❑ Fusion ❑ Other________________
Implant Vendor : ❑ DepuySynthes ❑ Globus ❑ Nuvasive ❑ Stryker ❑ RTI/Pioneer ❑ Aesculap
Reason for Choice: ❑ Demonstrated positive patient outcomes
❑ Familiarity with Products
❑ Product line flexibility and scope of products available
❑ Other:____

Physician Signature: ______________________________ Date: ____________ Time: ____________

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