McLaren HEALTH CARE

Pre-Scheduling Checklist for Sacral Nerve Neurostimulator Insertion Procedure for Urinary Incontinence

Instructions: Each item must be checked before scheduling the neurostimulator insertion procedure

Sacral Nerve Neurostimulator for Urinary Incontinence

Office Note Documentation: (Check if Present)	
	Conventional therapy that was tried and failed (documented behavioral, pharmacological and/or surgical corrective therapy)
	Patient does not have stress incontinence, urinary obstruction, or diabetes with peripheral nerve involvement
	50% or greater improvement through test stimulation
	Voiding diary recorded by the patient, demonstrating improvement during the test stimulation

Name _____ Date _____ Time _____
(Signature of person completing checklist)

PT.

MR.#/RM.

DR.