Mark Gordon
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
5221 Yellowstone Rd
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

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SPINAL CORD STIMULATOR REVISION CHECKLIST

Date: _____ Date of Procedure (if scheduled)_____

Claimant Name:_____ Claim Number: _____

Date of Birth:_____ Date of Injury: _____

Requesting Physician: _____

Claimant Diagnosis:	ICD-10 Code
1. Required diagnostics studies completed in the last 12 months:	☐ X-ray Date_____ ☐ MRI Date_____ ☐ CT Date_____
2. Current type of implanted device	☐ Spinal Cord Stimulator ☐ Dorsal Root Ganglion ☐ Other _____ _____ _____
3. Current device placed by Division?	☐ YES ☐ NO
4. Date the current device was placed	Date_____

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5. Location of implanted leads	_____ _____ _____
6. To be replaced	☐ Leads ☐ Generator
7. Reason for revision	☐ Leads fractured ☐ Leads migrated/wrong location for relief ☐ Generator unable to maintain charge ☐ Other _____ _____ _____
8. When did the stimulator last meet expectations for pain control?	Date:_____ Comments:_____ _____ _____ _____
9. Additional Comments	_____ _____ _____
10. Any contraindications: (select all that apply)	☐ YES ☐ NO

☐ Litigation in process

☐ History of drug abuse, alcohol use disorder
☐ History of suicidal ideation or suicide attempt
☐ Chronic high dose opioid use – (>90 MEQ/MED) SCS is not indicated for reduction of medications
☐ Elevated BMI/Obesity
☐ Current tobacco use
☐ History of infection/ sepsis/ localized infection
☐ Coagulopathy
☐ Previous surgery obliterating the spinal canal
☐ Inability for patient or caregiver to understand/ operate system
☐ Need for future MRI
☐ Psychological factors (see above)
☐ Pregnancy

Physician Signature _____

Date:_____

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