



GRANT MEMORIAL HOSPITAL

**EPIDURAL STEROID INJECTIONS (ESI) MEDICARE PRE-PROCEDURE REQUIREMENTS**

**In order to be compliant with Medicare’s ESI policy, the following information is required to be maintained in your records and a copy must be sent to the performing facility.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Provider: \_\_\_\_\_(Printed)

1. What are the patient’s symptoms? \_\_\_\_\_  
\_\_\_\_\_
2. How long has the patient had these symptoms? (minimum of 4 wks) \_\_\_\_\_
3. How have symptoms impacted the patient’s daily routine?  
\_\_\_\_\_  
\_\_\_\_\_
4. Pain Level (1-10) \_\_\_\_\_
5. What has the patient done to alleviate these symptoms? (eg physical therapy, exercise, analgesics, chiropractor, heat/cold therapy, etc.) (at least 4 wks) \_\_\_\_\_  
\_\_\_\_\_
6. Has the patient had a prior injection at the same anatomical location and using the same approach? \_\_\_\_\_ If yes, must be documentation of at least 50% of sustained improvement in pain relief measured from baseline using SAME scale for at least 3 months.
7. Has the patient had an MRI or CT scan of his/her back anywhere besides at Grant Memorial Hospital or ADR? If yes, where? \_\_\_\_\_  
\_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_