Medical Necessity for Joint Replacement Surgery

Primary Joint(s) Affected	Right	Left	Bilateral
Hip			
Knee			

Duration of Symptoms	
□ 3-6 months	□ 6-12 months □____Years
□ Other: (*specify)*	

Joint Replacement Related History

Osteoarthritis □ Mild □ Moderate □ Severe	□ Failure of Previous osteotomy
□ Inflammatory Arteritis	□ Osteonecrosis
□ Malignancy Type:	Location:
□ Failure of previous joint replacement surgery	Reason:
□ Avascular necrosis	□ Femoral head □ Knee
□ Fracture	Location:
Other:	

Failed non-surgical treatments (tried for at least 3 months)	
NSAID/COXIB Medication Trial	□ Yes □ No □ Contraindicated for the patient
Weight Loss	□ Yes □ No □ Contraindicated for the patient
Physical Therapy	□ Yes □ No □ Contraindicated for the patient
Intra-articular injection	□ Yes □ No □ Contraindicated for the patient
Braces, orthotics or assistive devices	□ Yes □ No □ Contraindicated for the patient
Other:	

Radiology Indications for Replacement
□ Subchondral cysts:
□ Subchondral sclerosis:
□ Periarticular osteophytes:
□ Joint Subluxation:
□ Joint Space Narrowing:

Highest Level of Walking Support (*for the affected joint that the pt currently uses to carry out activities, e.g. work, leisure*).
□ None/Orthotics
□ Brace/Cane
□ Crutches/Walker
□ Wheelchair

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Pain History

Select all that Apply	None	Mild	Moderate	Severe
Pain at rest (e.g. while sitting, lying down or causing sleep disturbance)				
Pain when weight bearing (e.g. walking, bending)				
Pain with passive ROM				
Pain related ADL limitation (e.g. putting on shoes, managing stairs, bathing, or cooking):				
Abnormal findings on physical exam related to most severely affected joint (e.g. deformity, instability, antalgic gait)				
Aggravating Factors: (list):				

Ability to walk without significant pain			
☐ Over 5 blocks	☐ 1-5 blocks	☐ Less than 1 block	☐ Household ambulator
☐ Safety Issues (*e.g. falls*): _____			

The patient's current medication regimen is controlling their joint pain:	Types of medications
☐ No ☐ Yes	☐ Narcotics ☐ NSAID/COXIB ☐ Over the counter
	Other (*specify*)

Highest Level of medication therapy to manage affected joint		
☐ PRN Pain Medication	☐ Regularly-scheduled medication use	☐ Maximum medical therapy appropriate for pt

Comments:

Date	**Time**	**ID#** ▶					**Physician Signature**