Medical Necessity for Lower Body Joint Replacement Surgery

Primary Joint(s) Affected	Right	Left	Bilateral
Hip Click here to enter text.	☐	☐	☐
Knee Click here to enter text.	☐	☐	☐

Duration of Symptons	
☐3-6 months	☐6-12 months
☐Other: (specify) Click here to enter text.	

Joint Replacement Related History

Osteoarthritis ☐Mild ☐Moderate ☐Severe Click here to enter text.
☐ Inflammatory Arthritis Click here to enter text.
☐ Failure of previous osteotomy Click here to enter text.
☐ Osteonecrosis Click here to enter text.
☐ Malignancy Type: Click here to enter text. Location: Click here to enter text.
☐ Failure of previous joint replacement surgery Reason: Click here to enter text.
☐ Avascular necrosis Click here to enter text. ☐Femoral head ☐Knee
☐ Fracture Click here to enter text. Location:Click here to enter text.
Other: Click here to enter text.
Notes Click here to enter text.

Failed non-surgical treatments (tried for at least 3 months)	
NSAID/COXIB Medication Trial	☐Yes ☐No ☐Contraindicated for the patient
Weight Loss Current BMI Click here to enter text.	☐Yes ☐No ☐Contraindicated for the patient
Physical Therapy (≥ 12 visits) DOS Click here to enter text.	☐Yes ☐No DOS ☐Contraindicated for the patient
Intra-articular injection DOS Click here to enter text.	☐Yes ☐No DOS ☐Contraindicated for the patient
Braces, orthotics or assistive devices	☐Yes ☐No ☐Contraindicated for the patient
Other (specify) Click here to enter text.	
Notes Click here to enter text.	

Radiology Indications for Replacement (need 2 or more):
☐ Subchondral cysts
☐ Subchondral schlerosis
☐ Periarticular ostophytes
☐ Joint Subluxation
☐ Joint Space Narrowing
☐ Bone on Bone articulation
Notes Click here to enter text.

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

Notes Click here to enter text.

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 join (e.g., deformity, instability, antalgic gait)	☐	☐	☐	☐
Aggravating Factors (list):	☐	☐	☐	☐
Notes Click here to enter text.				

Ability to walk without significant pain			
☐ Over 5 blocks	☐ 1-5 blocks	☐ Less than 1 block	☐ Household ambulatory
Safety Issues (e.g., falls): Click here to enter text.			
Notes Click here to enter text.			

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

Physical Exam (describe if present)	
☐ Deformity Click here to enter text.	
☐ Crepitus Click here to enter text.	
☐ Effussion(s) Click here to enter text.	
☐ Tenderness Click here to enter text.	
Range of Motion:	Click here to enter text.
Gait description: (specify with / without mobility aides)	Click here to enter text.

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

Comments: Click here to enter text.

Date Click here to enter a date.	Time Click here to enter text.	ID#				**Physician Signature** _____