Henry Mayo Newhall Hospital

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Indications for Total Joint Replacement

Rev. 01/04/2023

Patient's Name: _____ DOB: _____

Symptoms/Complaints

1. The patient has been complaining of: ☐ Right ☐ Left ☐ Hip pain ☐ Knee pain ☐ Shoulder pain
   For _____ months.
2. The patient's complaints include: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating
3. The pain is present: ☐ Daily ☐ Continuously ☐ Intermittenly ☐ Occasionally ☐ Nightly
4. Patient also reports difficulty with:
   ☐ Walking ☐ Climbing stairs ☐ Shower ☐ Food prep ☐ Driving ☐ Toilet
   ☐ Inability to perform the activities of daily living.
5. Other:_____

Physical Examination noted the following:

- ☐ Modification to ADLs (Activities of Daily Living)
- ☐ Pain scale rating of _____/10
- ☐ Pain elicited with all activity
- ☐ Difficult or impossible ambulation
- ☐ Difficulty with balanced walking
- ☐ Analgic gait
- ☐ Range of motion is limited at _____
- ☐ There is crepitus and grinding in the joint with movements, the pain is elicited with:
  ☐ Flexion ☐ Extension ☐ Rotational movements
  Other: _____

Conservative Measures:

1. The patient has been treated by conservative modalities and treatment for_____ months. The conservative measures have not improved the condition of this patient. The conservative management included:

- ☐ Non−Steroidal Anti−Inflammatories
- ☐ Steroid Anti−Inflammatories
- ☐ Corticosteroidals
- ☐ Visco−Supplementation Injections
- ☐ Diet Modification and Weight Loss
- ☐ Assisted Device
- ☐ Physical Therapy

2. These conservative measures provided:

- ☐ No relief
- ☐ Minimal relief
- ☐ Some relief but failed to provide adequate relief of symptoms.
- ☐ Conservative measures contraindicated because _____

Physical Therapy ☐ Has been prescribed ☐ Has not been prescribed ☐ Patient refused
☐ Was contraindicated due to medical issues or disease severity.

Attempts to strengthen the muscles and tendons surrounding the joining has been tried for _____ months and did not provide adequate results to diminish the pain and improve function ability.

MR43544

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Patient's Name: _____ DOB: _____

Occupational Therapy ☐ Has been prescribed ☐ Has not been prescribed ☐ Patient refused
☐ Was contraindicated due to medical issues or disease severity.

Attempts to improve activities of daily living has been tried for _____ months and did not provide adequate results to diminish the pain and improve functional ability.

Assistive Devices

1. To take the load off the joint and improve functional ability, the patient has been tried on assisting devices including: ☐ Cane ☐ Walker ☐ Crutches ☐ Bracing
2. They provided: ☐ No relief ☐ Minimal relief ☐ Some relief and symptom reduction

Diagnostic Testing Completed:

☐ MRI of _____ Date(s):_____
Result: _____

☐ Radiographs of _____ Date(s): _____
Result: _____

☐ Other: _____ Date(s): _____
Result: _____

The patient and the treating physician(s) have concluded that the patient has exhausted all conservative measures at this time and now will benefit from the **Total Joint Replacement** procedure indicated below. This treatment is necessary for the patient to return to a functional and pain manageable condition.

Procedure: ☐ Right ☐ Left ☐ Total Knee ☐ Total Hip ☐ Total Shoulder

Implant Vendor: ☐ DepuySynthes ☐ Exactech ☐ Smith and Nephew ☐ Stryker ☐ Zimmer/Biomet

Reason for Choice:
☐ Demonstrated positive patient outcomes
☐ Familiarity with Products
☐ Product line flexibility and scope of products available
☐ Other: _____

The patient is expected to be placed in:

☐ **Inpatient status** is reasonable and necessary due to increased risk of surgery due to the factors indicated below or to the need for prolonged in−hospital or skilled post−acute care in order to improve this patient's functional ability:

☐ ASA classification>II
☐ NYHA classification III or IV
☐ Chronic anti−coagulation
☐ Chronic or end stage renal disease
☐ Chronic opioid use or substance abuse
☐ Urological disorder causing voiding difficulties
☐ History of PE, emphysema, pulmonary fibrosis, lung carcinoma, or pulmonary hypertension
☐ Neurological disorders effecting movement including but not limited to: CVA with loss of functional mobility, Parkinson's, MS
☐ Other_____

☐ BMI>40
☐ Anemia
☐ Cognitive impairment
☐ History of falls in past three months

☐ Uncontrolled DM
☐ Chronic liver disease
☐ No home/social support

☐ **Outpatient status**

Physician's Signature: _____ Date: _____ Time: _____

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SUBMIT