### Surgical Procedure
<table>
<thead>
<tr>
<th>Description</th>
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### Diagnosis

- Primary Total Knee: [ ] Right [ ] Left
- Revision Total Knee: [ ] Right [ ] Left
- Unicompartmental: [ ] Medial [ ] Lateral
- Revision Unicompartmental to Total Knee Arthroplasty: [ ] Right [ ] Left
- Indications: *(one or more)*
  - Failure of osteotomy
  - Failure of Unicompartmental Arthroplasty
  - Avascular necrosis/osteonecrosis
- Other: ________________________________
- Revision Total Knee: [ ] Right [ ] Left
- Indications: *(one or more)*
  - Disabling pain
  - Fracture/dislocation of patella
  - Periprosthetic fracture
- Other: ________________________________

### Pain/Symptoms

- Scale: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10
- Location: ________________________________
- Not controlled by NSAIDS
- NSAID contraindicated: Allergy: ________________________________
- Not controlled by steroid injections
- Not improved with therapy
- Other: ________________________________
- Extreme/severe LOM (limitation of motion) joint/knee
- Other: ________________________________

### Imaging Results

- X-ray
- MRI
- Subchondral cysts: [ ] Femur [ ] Tibia [ ] Patella
- Subchondral sclerosis: [ ] Femur [ ] Tibia [ ] Patella
- Periarticular osteophytes: [ ] Femur [ ] Tibia [ ] Patella
- Joint subluxation
- Joint incongruity
- Angular deformity: [ ] Varus [ ] Valgus
- Joint space narrowing: [ ] Medial [ ] Lateral [ ] Moderate [ ] Severe
- Avascular necrosis: Location: ________________________________
- Other: ________________________________

### Other

- Advanced Joint Disease: ________________________________
- Other: ________________________________
- Not controlled by NSAIDS
- NSAID contraindicated: Allergy: ________________________________
- Not controlled by steroid injections
- Not improved with therapy
- Previous therapy failed
- Other: ________________________________
- Extreme/severe LOM (limitation of motion) joint/knee
- Other: ________________________________
- Other: ________________________________

### Functional disability

[ ] ADL [ ] sitting [ ] stairs [ ] exercise [ ] bathing [ ] sleep
[ ] sex [ ] standing [ ] walking [ ] weight bearing [ ] driving [ ] dressing
[ ] personal hygiene [ ] feeding [ ] meal prep [ ] wheelchair
[ ] transfers to: [ ] toilet [ ] transportation [ ] house cleaning [ ] therapy/includin cardiac

### Physician's Name (Print) ________________________________

Signature ________________
Date ________________
Time ________________
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TOTAL KNEE INDICATIONS CLINICAL NOTES

Pain/Symptoms:
☐ NSAIDS Duration: _______________________________
  • Contraindications (check): ☐ allergy ☐ ulcer ☐ BP ☐ medical
☐ Steroids
  • Oral Dates: _______________________________
  • Intraarticular Duration: _______________________________
  • Contraindicated
☐ Visco Supplemental Injections Dates: _______________________________
☐ Home Therapy Duration: _______________________________
☐ Physical Therapy Duration: _______________________________
☐ Other Therapy: _______________________________
☐ Activity/work modifications
☐ Assistive Devices: ☐ walker ☐ cane ☐ wheel chair ☐ brace ☐ crutches
☐ Arthroscopy
☐ Weight reduction
☐ Requires narcotic analgesics
☐ Failed period of conservative treatment: _______________________________

Co-morbidities:
Indicate: _______________________________

Pre-op Evaluation/clearance:
☐ Medical: _______________________________
  ☐ Cardiac: _______________________________
  ☐ Infectious disease: _______________________________
☐ Pulmonary: _______________________________
  ☐ Oncology: _______________________________
☐ GU: _______________________________
  ☐ Other: _______________________________

Findings:
☐ ROM Ext: _______________________________
  Flex: _______________________________
☐ Pain and motion
☐ Effusion
☐ Baker Cyst
☐ Crepitation
☐ Instability
☐ Loss of motion: ☐ Ext ☐ Flex
☐ Crepitation: _______________________________
☐ Circulation: _______________________________
☐ Sensation: _______________________________
☐ Gait: _______________________________
☐ Other: _______________________________

Risks Discussed: (includes but not limited to list)
☐ Infection ☐ DVT/PE
☐ Nerve/artery/bone/injury intra-op ☐ Device failure or loosening
☐ Medical/Anesthetic complications ☐ Painful stiff knee
☐ Possible need for additional surgery ☐ Bleeding
☐ Wound (operative site) healing ☐ Smoking cessation prior to surgery
☐ High Risk (reason): _______________________________
  ☐ Other: _______________________________

In my opinion, this patient meets criteria for Total Knee Arthroplasty/Total Knee Revision.

Physician’s Name (Print) _______________________________ Signature _______________________________ Date __________ Time __________

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TOTAL KNEE INDICATIONS CLINICAL NOTES