### Surgical Procedure:

**Description:**

### Diagnosis:

- [ ] Primary Total Knee: [ ] Right [ ] Left
- [ ] Unicompartmental: [ ] Medial [ ] Lateral
- [ ] Revision Unicompartmental to Total Knee Arthroplasty: [ ] Right [ ] Left

**Indications: (one or more)**

- [ ] Failure of osteotomy
- [ ] Distal femur fracture
- [ ] Failure of Unicompartmental Arthroplasty
- [ ] Malignancy
- [ ] Avascular necrosis/osteonecrosis
- [ ] Proximal tibia fracture
- [ ] Other: ________________________________

- [ ] Revision Total Knee: [ ] Right [ ] Left

**Indications: (one or more)**

- [ ] Disabling pain
- [ ] Fracture/dislocation of patella
- [ ] Periprosthetic fracture
- [ ] Wear/failure of device
- [ ] Instability of knee joint
- [ ] Functional disability: ________________________________

### Pain/Symptoms:

- [ ] Scale: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

**Location:**

**Disabling:**

- [ ] Work
- [ ] ADL
- [ ] Recreation/sports/exercise
- [ ] Cardiac rehabilitation
- [ ] Other: ________________________________

**Not controlled by NSAIDS**

[ ] NSAID contraindicated: Allergy: __________________________ [ ] Ulcer [ ] GI disease [ ] Other: ________________________________

**Not controlled by steroid injections**

[ ] Previous therapy failed

**Unable to tolerate physical therapy**

[ ] Other: ________________________________

**Extreme/severe LOM (limitation of motion) joint/knee**

[ ] Contraindicated

**Interferes/prevents/severely limits (check all that apply):**

- [ ] 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/including cardiac

### 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:**

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**Physician's Name (Print):** __________________________

**Signature:** __________________________

**Date:** __________________________

**Time:** __________________________
### 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:**
- Duration: _______________________________

**Activity/work modifications**
- Assisting Devices: [ ] walker  [ ] cane  [ ] wheel chair  [ ] brace  [ ] crutches

**Arthroscopy**
- Requires narcotic analgesics

**Failed period of conservative treatment:**

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**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
- 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.*

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**Physician’s Name (Print)**

**Signature**

**Date**

**Time**

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