MEDICAL NECESSITY FORM

Major Joint Replacement or Reattachment of Lower Extremity

Patient Name:	Date of Birth:	Medical Record #:	Physician Name:

Description of pain (onset, duration, character, aggravating or relieving factors);

Limitation of Activities of Daily Living (ADLs) specify;

Safety issues (e.g., falls);

Contraindications to non-surgical treatments

Listing/Description of failed non-surgical treatment *(check all that apply)*:

- ☐ Medications (anti-inflammatories; analgesics): _____
- ☐ Weight loss
- ☐ Physical Therapy
- ☐ Intra-articular injections: _____
- ☐ Braces, orthotics or assistive devices

Comorbidities:

Documentation of Joint Physical Exam *(check all that apply)*:

- ☐ Deformity: _____
- ☐ Range of Motion Limitations: _____
- ☐ Crepitus
- ☐ Effusions
- ☐ Tenderness
- ☐ Gait Description *(with or without mobility aides)*: _____

Investigations, Results, i.e. Radiology or MRI:

Physician documentation of clinical judgment to support medical necessity: Impression:

Planned Procedure:

Physician Signature _____ Date _____

Account Number:	MR Number:
Patient Name:	
Admit Date:	

DOB	Age	Sex	HT	WT	RM-BD	PT	Svc	FC

Allergies:

Attending Physician Name:

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