NOTE: Incomplete and / or unsigned requistions will be returned

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

MRI KNEE APPROPRIATENESS CHECKLIST

This checklist is required for all outpatient MRI knee referrals.

Please include with MRI requisition.

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Family Physician: _____

Date	Referring MD	Signature

CHECK ANY/ALL THAT APPLY:

☐ **Recent Knee X-rays Recommended for All Patients**

Required for: Patients greater than or equal to 55 years old
Suspected osteoarthritis (weight bearing views)
History of trauma

☐ **Other Knee Imaging**

What: _____

When: _____

Where: _____

MRI *is* recommended for:

- ☐ Locked knee/Mechanical symptoms (unable to fully extend knee with relaxed muscles)
- ☐ Suspected ligamentous injury. Which ligament(s): _____
- ☐ Persistent swelling/effusion despite conservative therapy for 4 - 6 weeks
- ☐ Suspected soft tissue or bone tumour

MRI *is NOT* recommended if there is:

- ☐ Moderate or sever osteoarthritis without locking or extension block
  MRI is unlikely to alter patient management

Consider MRI if *all* of the following are present

- ☐ Absent or mild osteoarthritis
- ☐ Persistent unexplained pain greater than 3 months
- ☐ Failed conservative therapy (physiotherapy and anti-inflammatories)
- ☐ Patient is surgical/arthroscopy candidate

Additional Clinical Information

Please provide any additional information relevant to this request.
Include arthroscopic and surgical reports.