MRI KNEE APPROPRIATENESS CHECKLIST

This checklist is required for all outpatient MRI knee referrals.
Please include with MRI requisition.

Patient label placed here, or minimum information below required
Patient Name:
Date:
Date of Birth (YYYYMMDD):
Gender:
MRN:

CHECK ANY/ ALL THAT APPLY:

A. ☐ Recent Knee X-Rays Recommended For All Patients (weight bearing views)	B. Prior Knee Imaging (supports correlation with MRI images)
Required for: Patients ≥ 55 years old Suspected osteoarthritis History of Trauma Pediatric patients with trauma	What: _____ When: _____ Where: _____

C. MRI is *NOT* recommended if there is

☐ Moderate to severe osteoarthritis without locking or extension block

MRI is unlikely to alter patient management, and is not needed for orthopedic referral

D. MRI *IS* recommended for:

☐ Locked knee/Mechanical symptoms (unable to fully extend knee with relaxed muscles)
☐ Suspected ligamentous injury
Specify which ligaments: _____
☐ Persistent swelling/effusion despite conservative therapy for 4-6 weeks
☐ Suspected soft tissue or bone tumor

E. Consider MRI if *ALL* the following are present

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

MRI is indicated if any of box D is checked, or all criteria of box E

F. Additional Clinical Information (please provide any additional information relevant to this request)

Please include arthroscopic and surgical reports

_____ Referring Physician Name
_____ Signature
_____ Date