South West **LHIN**

MRI KNEE APPROPRIATENESS CHECKLIST

Patient label placed here, or minimum information below required

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

Referring Physician Name: _____

Patient Name:
Date:
Date of Birth (YYYYMMDD):
Gender:
MRN:

CHECK ANY/ALL THAT APPLY:

A. ☐ Recent Knee X-rays Recommended For All Patients

Required for: Patients ≥ *55 years old*
Suspected *osteoarthritis* (weight bearing views)
History of *trauma*

B. ☐ Other Knee Imaging

What: _____

When: _____

Where: _____

C. 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

D. MRI *is NOT* recommended if there is:

- ☐ Moderate or severe osteoarthritis without locking or extension block

  MRI is unlikely to alter patient management

E. Consider MRI if *all* of the following are present:

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

F. Additional Clinical Information

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

_____ _____
Referring Physician Signature Date