Ontario
South West Local Health Integration Network

Choosing Wisely Canada™

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/HCN:

CHECK ANY/ALL THAT APPLY:

A. ☐ Recent Knee X-rays Recommended For All Patients	B. ☐ Other Knee Imaging
Required for: Patients ≥ *55 years old* Suspected *osteoarthritis* (weight bearing views) History of *trauma*	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

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