The Christ Hospital Health Network

Patient Name: _____

Patient DOB: _____

Joint Replacement Questionnaire

Please complete this information for **major joint replacement surgeries** for traditional Medicare and Medicaid patients only. Return this questionnaire with the patients Surgery Reservation Packet. In addition to this questionnaire, the office note when the need for surgery was determined should also be submitted with the packet and include detailed information to support the decision for surgery, including but not limited to:

- decline in functional status and what the patient has experienced due to this decline,
- increase in pain and how it affects the patient (including patients description), and
- progression of disease process.

1. Prior to determining surgical intervention, please indicate conservative treatment attempts and the patients response to these treatments (check all that apply):

☐ NSAIDs ☐ Cortisone Injection ☐ Hyaluronate Injection ☐ Physical Therapy ☐ HEP ☐ Brace ☐ Arthroscopy ☐ Weight Loss ☐ Limitation of activities

☐ Icing ☐ Elevating ☐ Heat ☐ Pain relievers ☐ Other

Treatment details and patients response:_____

_____

2. Has this patient been treated for chronic pain with opioid use?
   - ☐ Yes
   - ☐ No

3. Please check the box to indicate significant patient co-morbidities (Check all that apply):
   - ☐ Myocardial Infarction (MI)
   - ☐ Congestive Heart Failure (CHF)
   - ☐ Diabetes Mellitus (DM)
   - ☐ Chronic Hypertension (HTN)
   - ☐ Chronic Obstructive Pulmonary Disease (COPD)
   - ☐ Stroke
   - ☐ Cardiac
   - ☐ Arrhythmia
   - ☐ Respiratory
   - ☐ Deep venous thrombosis (DVT)
   - ☐ Pulmonary Embolism (PE)
   - ☐ Obstructive Sleep Apnea (OSA)
   - ☐ Co-Agulaopathies

4. Due to multiple comorbidities this patient is at higher risk for post-operative complications that include but are not limited to infection, DVT, PE, cardiac issues and will require close monitoring by medical personnel?
   - ☐ Yes
   - ☐ No

5. For Medicare Patients: Please provide a description of how co-morbidities or relevant risk factors may affect the care of the patient and therefore require a patient to need medically necessary care that would cross over two midnights (keep the patient in the hospital for 2 days). What is the plan for inpatient care post-surgery?

6. Please indicate negative impact to the patient's Activities of Daily Living (ADLs) (Check all that apply):

☐ Sitting	☐ Standing	☐ Walking	☐ Going up/down stairs	☐ Getting in/out of the car	☐ Bending	☐ Squatting
☐ Kneeling	☐ Putting on shoes/socks	☐ Dressing self	☐ Doing hair	☐ Lifting	☐ Writing	☐ Driving
☐ Putting seatbelt on	☐ Getting up from seated p...	☐ Sleeping	☐ Bathing	☐ Reaching into cabinet	☐ Shopping	☐ Cooking
☐ Cleaning	☐ Doing dishes	☐ Caring for spouse/child/...	☐ Yardwork	☐ Sporting activities	☐ Regular exercise program	☐ Other

7. Is there Radiographic Evidence of End Stage Joint Disease?
   - ☐ Yes
   - ☐ No

Comment on x-ray report:_____

_____

8. Does the patient live more than 1 hour from The Christ Hospital facility where the surgery will be performed?
   - ☐ Yes
   - ☐ No

9. Does the patient have a competent caregiver to provide post-discharge care?
   - ☐ Yes
   - ☐ No

10. Are there other significant social issues that would put the patient at high risk for going home after surgery? (Check all that apply):
   - ☐ Patient lives alone
   - ☐ Living Situation (housing; utilities; water, etc.)
   - ☐ Personal Safety
   - ☐ Reliable access to a sufficient quantity of affordable, nutritious food
   - ☐ Transportation
   - ☐ Social Isolation
   - ☐ Spouse/Family member that depends on patient for ongoing care/support
   - ☐ Financial Stress
   - ☐ History of/Risk of Falling

Comments:

11. Are there steps leading into the patient's home or within the home?
   - ☐ Yes Total of ____ Steps
   - ☐ No

12. Do you anticipate the need for skilled nursing facility or inpatient rehabilitation based on patient's clinical presentation?
   - ☐ Yes
   - ☐ No