TWIN CITIES ORTHOPEDICS

Robert LaPrade, MD, PhD
Complex Knee Surgeon
Sports Medicine

Tel: 612-615-2240

CLINICAL CASE AND MRI REVIEW

Dr. Robert LaPrade welcomes your Clinical Case and MRI Review for a fee of $300. This fee is not billed to insurance nor applicable toward future services. Once your completed packet has been received, Dr. LaPrade will review it and have one of his team members contact you with his findings. Please keep in mind that Dr. LaPrade cannot offer a full recommendation on imaging alone, he will need to complete a physical examination to finalize treatment recommendations.

Please follow the instructions below to submit your review:

1. Submit your $300 secure credit card payment at https://tcomn.com/pay-bill/ and enter "**4567000**" in the "**Acct #**" required field of the online form.
2. Include in your packet:
   - Completed Case Review/Patient History forms
   - Imaging on CD (MRI, CT, Xrays) completed within the last 4 months (electronic transfer/mail is not permitted due to size of imaging and variable software)
   - Operative, MRI, & CT reports
   - Self-addressed envelope **(with proper postage)** to return imaging, if needed
3. Mail your packet to :

Twin Cities Orthopedics
4010 W. 65th St.
Edina, MN 55435
Attn: Amanda Peña

*****We recommend patients gather and mail their own materials in order to avoid delays and shipping errors from image centers and/or clinics.*****

Please direct any questions regarding this process to Amanda Peña at 612-615-2240.

We look forward to the opportunity to help you!
Dr. LaPrade and Team

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Clinical Case and MRI Review Patient Consent Form

Consent for Clinical Case and MRI Review &
Authorization for the Release of Medical Information

Patient Information

Name: _____
Address: _____
_____
_____
Date of Birth: _____
Home Phone: _____

☐ I am 18 years or older. ☐ I am under the care of a physician

Because there is not an opportunity for a physical examination, this Clinical Case and MRI Review differs from diagnostic services typically provided by a physician. Without the benefit of examining you in person and observing your physical condition, Dr. LaPrade may not be aware of facts or information that could influence or be critical to his opinion. By requesting this service, you acknowledge that you are aware of this limitation and agree to assume the risk of this limitation.

Please read the following and indicate agreement to each paragraph by checking the "I agree" box below that paragraph:

I understand that the Clinical Case and MRI Review that I will receive from Dr. LaPrade is preliminary and limited because it does not have information typically obtained through a physical examination. The absence of a physical examination could affect Dr. LaPrade's ability to diagnose my condition or injury. This Clinical Case and MRI Review is not intended to replace a full medical evaluation or an in-person visit with a physician. I agree to solely assume the risks of the limitations associated with this review and understand that no warranty or guarantee is made to me concerning a specific result or cure of my condition or injury. I have read and agree to be bound by these conditions.

☐ Yes, I agree ☐ No, I do not agree

I have received the Notice of Privacy Practices of Twin Cities Orthopedics and understand the explanation of how they may use and disclose confidential health information that identifies me. I consent to let Twin Cities Orthopedics use and disclose health information about my Clinical Case and MRI Review. I can revoke my consent in writing at any time except to the extent that Twin Cities Orthopedics has already relied on my consent.

☐ Yes, I agree ☐ No, I do not agree

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Authorization for Clinical Case and MRI Review

I understand that if I do not sign the below authorization, Dr. Robert LaPrade will not be able to provide me with a Clinical Case and MRI Review. I also understand that any disclosure that Twin Cities Orthopedics makes to a third party, such as the physician identified above, may or may not be protected by privacy laws.

This authorization is subject to revocation at any time, except to the extent that action has been taken thereon, and this authorization will expire one year from the date of authorization written below.

_____	_____	_____/_____/____
Signature of Patient**	Printed Name	Date Signed

**If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney, Legal Guardian) must accompany the authorization when presented. The form must be signed, dated, witnessed by two people, and notarized when possible.

Exception: parent is signing for patient under 18.

Robert F. LaPrade, MD, PhD

PATIENT HISTORY FORM

Name: _____ Today's Date _____

Date of Birth: _____ Age: _____ Height/Weight: _____

History of Injury

Work Related? ❒Yes ❒No Motor Vehicle Accident? ❒Yes ❒No Sport Accident? ❒Yes ❒No _____ Sport

Which Knee: ❒R ❒L Hand dominance ❒R ❒L

Date of Injury: _____ If chronic, list how long have you had this pain? _____

Please briefly describe, in your own words, how the original injury occurred:

_____

_____

_____

_____

How does this injury limit your activity?:

_____

_____

_____

_____

Rate your pain using a scale of 1-10 (10 is most painful): Rest: _____ At its worst: _____

Is the pain: ❒Constant ❒Occasional Has it been: ❒Worsening ❒Stable ❒Improving

Describe the pain: ❒Sharp ❒Dull ❒Aching ❒Stabbing ❒Throbbing ❒Sensitive to Touch

Pain at night? ❒Yes ❒No Does the pain awaken you or keep you from sleep? ❒Yes ❒No (❒Awaken ❒Keep)

Which symptoms are you experiencing?

❒Locking ❒Catching ❒Giving Way/Instability ❒Popping ❒Grinding ❒Bruising ❒Numbness

❒Tingling ❒Pain ❒Weakness ❒Swelling ❒Other: _____

What, if anything, improves symptoms:

❒Rest ❒Activity ❒Cold Therapy ❒Heat Therapy ❒Medication ❒Other: _____

What, of anything, worsens your symptoms:

❒Inactivity ❒Exercise ❒Other: _____

Which treatments have you tried for this injury?

❒Nothing ❒Exercise ❒Ice ❒Decreased Activity ❒Bracing

Injections: _____

Physical Therapy _____ Acupuncture _____

Medications _____ Chiropractic _____

Have you been evaluated by another physician for this injury? ❒Yes ❒No Where you referred? ❒Yes ❒No

If yes, who/where: _____

Are you interested in surgery for this problem? ❒Yes ❒No ❒Unsure

Have you had any of the following tests/studies?

	Test (Month/Year)	Facility (Clinic/Hospital)
Xray		
MRI		
CT Scan		
Other		