TWIN CITIES ORTHOPEDICS

Robert LaPrade, MD, PhD
Complex Knee Surgeon
Sports Medicine

Tel: 612-615-2240

CLINICAL CASE AND MRI REVIEW

Dr. Robert LaPrade offers a Clinical Case and MRI Record Review for individuals seeking an independent expert opinion based on submitted medical records and imaging.

The fee for this service is $300 USD. This fee is not billed to insurance and is not applicable toward future services.

Once your completed submission packet has been received and verified, Dr. LaPrade will review the materials and a member of his clinical team will communicate his findings.

Please note that because this review is based solely on submitted records and imaging, a full treatment recommendation may not be possible without an in-person physical examination.

UNDERSTANDING THE NATURE OF A RECORD-BASED SECOND OPINION

Many individuals seeking a second opinion are navigating complex medical decisions, prior treatments, or differing recommendations. This service is designed to provide an independent expert assessment based solely on the medical records and imaging submitted.

- It is important to understand:
- This review is limited to the documentation provided.
- Recommendations reflect independent clinical judgment.
- Medical opinions may differ, particularly in complex orthopedic cases.
- In some cases, a recommendation may focus on conservative or non-surgical treatment based on the information available.
- A surgical recommendation does not guarantee candidacy or outcome.

This service is intended to offer clarity and perspective. It does not replace ongoing care with a treating physician and does not include continued medical management.

If additional review is desired after findings are delivered, a new submission is required.

SCOPE OF REVIEW

Each submission is limited to one body region (for example: knee, shoulder, hip, or ankle).

If review of additional joints or injuries is desired, each body region requires a separate submission and fee.

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SUBMISSION INSTRUCTIONS

Please follow the instructions below to submit your review:

1. **Submit Payment -** Your $300 secure credit card payment by clicking on this link: www.drlaprade.com/pay and enter the following information in the iHealth form to reach the payment screen:

   - Account ID: **4567000**
   - Birth Date: **01/01/1801**
   - Complete the ***I'm not a robot steps***
   - Click the ***Look up my current balance*** button
   - Enter your email address for the receipt
   - An overview may appear about the balance on the account – this should be zero.
   - Select ***Amount to Pay*** in the box for payment options if needed.
   - Enter the amount to pay: **300.00**
   - Click the ***Pay now*** button
   - Pay with new card should be selected. Enter the Cardholder details requested.
   - Click the *Pay $300.00* button.
   - Please email your receipt to Amanda (AmandaPena@tcomn.com) when completed.

2. **Include in your packet -** Your mailed packet must include the following materials related to one body region only:

   - Completed Case Review/Patient History forms
   - Signed Clinical Case & MRI Review Consent Form
   - Signed Clinical Record Review Acknowledgment
   - Imaging on CD (MRI, CT, X-ray) 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

   Incomplete submissions cannot be reviewed and may delay the review process.

3. **Mail your packet to:**

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

We recommend that patients gather and mail their materials themselves to help avoid delays or shipping errors from imaging centers or clinics.

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Important:
For your protection, we recommend using a trackable shipping method when mailing your materials. The review process begins only after payment and all required materials have been received and verified by our office.

If you have tracking confirmation showing delivery but have not received acknowledgment within 5 business days, please contact our office to confirm receipt.

QUESTIONS

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

We appreciate the opportunity to review your case.

Dr. LaPrade and Team

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		

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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: _____

Cell Phone: _____

Email: _____

☐ 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

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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.

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CLINICAL CASE & MRI RECORD REVIEW ACKNOWLEDGMENT

By signing below, I acknowledge and agree to the following:

1. I understand this service is a record-based expert opinion and does not establish an ongoing physician-patient relationship.
2. I understand the review is limited to the medical records and imaging I submit.
3. I understand recommendations may differ from other providers and reflect independent clinical judgment.
4. I understand this service does not include ongoing medical management or TeleHealth consultation.
5. I understand that up to two clarification questions may be submitted within 7 days of receiving findings.
6. I understand additional review requests require a new submission and fee.
7. I understand the practice is not responsible for materials lost or damaged in transit.
8. I understand the review will not begin until payment and all required materials are received and verified.

I acknowledge I have read and understand the Clinical Case & MRI Review Policy.

Patient Name: _____

Signature: _____

Date: _____