MIDWEST
ORTHOPAEDICS
AT RUSH

Clinical Case & Imaging Review

Jorge Chahla, MD, PhD

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Clinical Case and Imaging Review

Introduction and Checklist

Thank you for submitting your recent inquiry for a clinical case and imaging review to be performed by Dr. Jorge Chahla, MD, PhD. We appreciate the value you place in Dr. Chahla's opinion. Dr. Chahla welcomes your request for a fee of $300.00. Please note that this fee will not be billed to insurance, nor will it be applicable towards any future service with our office.

Please see below for instructions on submitting your completed packet for review. After your completed packet has been received, payment will be collected via your preferred method indicated below.

Once your completed packet for review and payment have been received, a team member will be in contact with you to schedule a virtual telemedicine appointment to discuss Dr. Chahla's findings. Again, this appointment will not be billed through insurance, but rather, it is included in the above clinical case and imaging review fee of $300.00. Please keep in mind that Dr. Chahla cannot offer a full recommendation on imaging alone. To finalize a diagnosis and treatment plan, a physical examination would need to be completed at one of our Midwest Orthopaedics at Rush clinical locations.

Please follow the instructions below to submit your review. Please note: the clinical case/Imaging review and virtual telemedicine appointment will not be scheduled until all components of the requested packet below have been received.

INCLUDE IN YOUR REVIEW PACKET

- ☐ A copy of this document with indicated preferred payment method selected (*see next page)*
- ☐ Completed Case Review/Patient History Form (*see next page for Form*)
- ☐ Imaging on CD (MRI, CT, X-rays) completed within the last 4 months. (*Note: electronic transfer/mail is not permitted due to size of imaging and variable software*)
- ☐ Operative Report (*if applicable*), MRI Report, CT Report
- ☐ If you would like imaging returned: Self-addressed envelope with proper postage.

MIDWEST ORTHOPAEDICS AT RUSH

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MAIL YOUR REVIEW PACKET

Mail your completed packaged to the following address:

Midwest Orthopaedics at Rush
Attn: Dr. Jorge Chahla
1611 West Harrison Street, Suite 300
Chicago, Illinois 60612

SUBMIT PAYMENT

Below, please indicate by selecting the box next to your preferred method for submission of your $300.00 secure payment:

- ☐ Submit secure Credit Card payment over phone.
- ☐ Request a link be sent via email to submit secure payment online.

TO AVOID DELAYS AND SHIPPING ERRORS:

WE HIGHLY RECOMMEND PATIENTS PERSONALLY GATHER ALL OF THEIR OWN REQUIRED MATERIALS AND MAIL TOGETHER AS ONE PACKET.

Please direct any questions regarding the process of submitting a Clinical Case and Imaging Review to the Chahla Administrative Team at chahlaadmin@rushrtho.com or by phone at 312.432.2531.

We thank you for the opportunity to review your case.
We look forward to helping you on your road to recovery!

Dr. Chahla and Team

MIDWEST ORTHOPAEDICS AT RUSH

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Clinical Case and Imaging Review

Patient History Form

Patient Information	**Name (Last, First, MI)**		**Today's Date:**	**MRN (*Office Use Only*):**
	Patient Email Address:		**Date of Birth:**	**Social Security #:**
	Street Address:			
	City:	**State:**	**Zip:**	**Sex:** ☐ Male ☐ Female ☐ Other
	Home Phone #:	**Cell Phone #:**		**Work Phone #:**
	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Occupation:**	**Employer:**	**Employment Address:**

Guarantor	**Name (Last, First, MI)**	**Relationship to Patient:**	
	Social Security #:	**Date of Birth:**	
	Employer Name:	**Employer Address:**	
	City:	**State:**	**Zip:**

Physician Info	**Referring Physician's Name (*if applicable*)**	**Physician Phone #:**
	Primary Physician's Name:	**Physician Phone #:**

Assignment of Benefits & Release	Please read the following and sign below: I hereby authorize that I understand that I am financially responsible for the review fee of $300.00. I understand that my insurance company will not be billed for the clinical case/imaging review. I understand that I will need to submit my insurance information and travel to a Midwest Orthopaedics at Rush clinical location if I would like to receive treatment. By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. By signing below, I acknowledge that I agree to the financial policy described on the back of this form. **Signature:** _____ **Date:** _____

MIDWEST ORTHOPAEDICS AT RUSH

Jorge Chahla, MD, PhD

Name: _____ **Today's Date:** _____

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

How did you hear about us? _____

What brings you in today (Chief Complaint)**?** ☐ **Shoulder** ☐ **Hip** ☐ **Knee**

Which side? ☐ **Left** ☐ **Right** ☐ **Bilateral** **Hand Dominance:** ☐ **Left** ☐ **Right**

Date of Injury/Onset: _____

History of Injury?

☐ **Work Injury** Date: _____

☐ **Sport Injury** Date: _____

☐ **Motor Vehicle Accident** Date: _____

In your own words, describe the original injury/onset of symptoms: _____

_____

_____

_____

_____

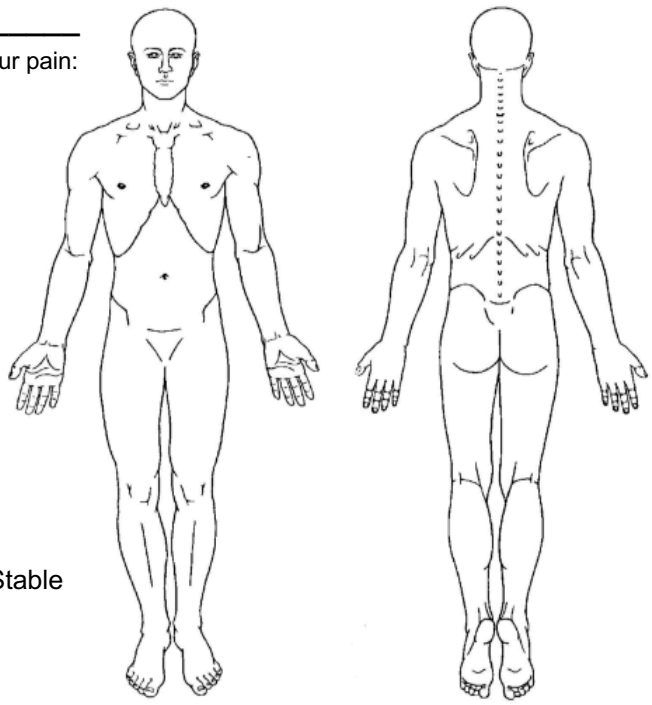
How does this injury limit your activity? _____

_____

_____

Where is your pain? _____

Place an "X" Mark in the drawing for the location of your pain:



Rate your pain:

Legend: 0 = No pain 10 = Extreme Pain

Right now: _____/10

At Rest: _____/10

At Worst: _____/10

Describe your pain:

☐ Sharp ☐ Stabbing ☐ Dull ☐ Nagging

☐ Burning ☐ Aching ☐ Sensitive to Touch

Is your pain: ☐ Constant ☐ Occasional

Is your pain: ☐ Worsening ☐ Improving ☐ Stable

MIDWEST ORTHOPAEDICS AT RUSH

Jorge Chahla, MD, PhD

Which symptoms are you experiencing?

☐ Locking ☐ Catching ☐ Giving Way/Instability ☐ Popping ☐ Grinding ☐ Bruising ☐ Pain
☐ Numbness ☐ Tingling ☐ Weakness ☐ Swelling ☐ Other _____

What aggravates or makes the pain worse? _____

_____

_____

What improves or makes the pain better? _____

_____

_____

Activity

Do you participate in sports? ☐ Yes ☐ No **If Yes, which sport?** _____
Level? ☐ High School ☐ College ☐ Professional ☐ Recreational

Do you exercise? ☐ Yes ☐ No **If Yes, how often?** _____
Are you still active, or has your condition altered your activity in any way? _____

_____

Previous Imaging

Have you had any of the following tests/studies?

	Test (Month/Year)	Facility (Clinic/Hospital)
X-ray	_____	_____
MRI	_____	_____
CT Scan	_____	_____
Other	_____	_____

MIDWEST ORTHOPAEDICS AT RUSH

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Previous Conservative Treatment

Have you seen any other physicians for your condition? ☐ Yes ☐ No
If yes, who did you see and what was the diagnosis you were given? _____

_____

_____

Which treatments have you tried for this condition?

Rest	**Did it help?** ☐ Yes ☐ No	
Activity Modification	**Did it help?** ☐ Yes ☐ No	
Physical Therapy	**Did it help?** ☐ Yes ☐ No	Date of Last Session: _____
Cold Therapy	**Did it help?** ☐ Yes ☐ No	
Medication	**Did it help?** ☐ Yes ☐ No	What Medications: _____
Injection	**Did it help?** ☐ Yes ☐ No	Which Injection(s)? _____ Date of Last Injection:_____
Chiropractor	**Did it help?** ☐ Yes ☐ No	Date of Last Session: _____

Previous Orthopedic Surgical History

Procedure	Date of Procedure	Facility & Surgeon

☐ No Previous Orthopedic Surgical History

Pertinent Past Medical History

_____

_____

_____

_____

_____

_____

Social History

Do you Smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

Do you drink Alcohol? ☐ Yes ☐ No

If yes, how much/week? _____

Do you do illicit drugs? ☐ Yes ☐ No

What illicit drug? _____

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Patient Consent Form

Patient Information			
	Name (Last, First, MI)		**Date of Birth:**
	Street Address:		
	City:	**State:**	**Zip:**
	Preferred Phone #:	**Patient Email Address:**	

This is a legal consent form for Clinical Case and Imaging Review as well as Authorization for the Release of Medical Information.

Because there is not an opportunity for a physical examination, this Clinical Case and Imaging Review differs from diagnostic services typically provided by a physician. Without the benefit of examining you in person and observing your physical condition, Dr. Chahla 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.

☐ I consent that I am 18 years of age or older.

☐ I consent that I am the legal guardian for the minor patient under the age of 18 years.

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 Imaging Review that I will receive from Dr. Chahla 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. Chahla's ability to diagnose my condition or injury. This Clinical Case and Imaging 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.

MIDWEST ORTHOPAEDICS AT RUSH

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

☐ Yes, I agree. ☐ No, I do not agree.

Authorization for Clinical Case and Imaging Review

I understand that if I do not sign the below authorization, Dr. Jorge Chahla will not be able to provide me with a Clinical Case and Imaging Review. I also understand that any disclosure that Midwest Orthopaedics at Rush 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.

If you agree to the terms set forth above, please sign and date this form in in the space provided below and return to the office of Dr. Jorge Chahla with your completed Clinical Case and Imaging Review Packet. Please note that we will not move forward on any of the above services without this signed document.

If you have any questions, please contact: Dr. Jorge Chahla's Administrative team at P:312.432.2531 / Email: chahlaadmin@rushortho.com

Print Name	Signature	Date

Please Note: If other than patient's signature, a copy of legal papers verifying authority (example: 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 to this: Parent signing for patient under the age of 18 years old.