

KNEE FOLLOW-UP

— X-RAY ORDER

MIDLANDS
orthopaedics
& NEUROSURGERY

***Patient - Please fill your NAME and DATE OF BIRTH before visiting the office.**

R_x

FOR (NAME) _____

DOB: _____

ADDRESS _____

DATE _____

POSTOP PATIENTS - Please choose/circle ONE section (either 1, 2, or 3) to ensure the appropriate x-rays are obtained from the patient's radiology facility.

1. LEFT

- i. Presence of left artificial knee joint - **Z96.652**

2. RIGHT

- i. Presence of right artificial knee joint - **Z96.651**

3. BILATERAL

- i. Presence of artificial knee joint, bilateral - **Z96.653**

Views (please include each of the following)

1. AP
2. Lateral
3. Sunrise
4. 45° flexion

Please provide the patient with a CD digital copy of these x-rays for my review, and mail to:

Midlands Orthopaedics & Neurosurgery
ATTN: Gross Follow-Up
1910 Blanding Street Columbia, SC 29201

Thomas
P Gross,
MD

Digitally signed
by Thomas P
Gross, MD
Date: 2026.02.05
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