



K1 Knee Primary

Patient Addressograph

Important:

Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Dataset Form Component Labels Sheet'. Please ensure that all sheets are stapled together.

All fields are Mandatory unless otherwise indicated

REMEMBER! MAKE A NOTE OF THE NJR REFERENCE NUMBER WHEN YOU ENTER THIS DATA

NJR REF:

PATIENT DETAILS

| | | | |
|---|----------------------------------|-----------------------------|--|
| Patient Consent Obtained | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Recorded <input type="checkbox"/> |
| Patient Hospital ID | | | |
| Body Mass Index (enter either H&W OR BMI OR tick Not Available box) | Height (IN CM) Weight (IN KG) | BMI | Not Available <input type="checkbox"/> |

PATIENT IDENTIFIERS

| | | | |
|---------------------------|---|---------------------------------|---|
| Forename | | | |
| Surname | | | |
| Gender | Male <input type="checkbox"/> | Female <input type="checkbox"/> | Not Known <input type="checkbox"/> Not Specified <input type="checkbox"/> |
| Date of Birth | DD/MM/YYYY | | |
| Patient Postcode | Overseas Address <input type="checkbox"/> | | |
| NHS Number (if available) | | | |

OPERATION DETAILS

| | | | |
|-------------------|----------------------------------|---|---|
| Hospital | | | |
| Operation Date | DD/MM/YYYY | | |
| Anaesthetic Types | General <input type="checkbox"/> | Regional - Nerve Block <input type="checkbox"/> | Regional - Epidural <input type="checkbox"/> Regional - Spinal (Intrathecal) <input type="checkbox"/> |
| Patient ASA Grade | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> |
| Operation Funding | NHS <input type="checkbox"/> | Independent <input type="checkbox"/> | |

SURGEON DETAILS

| | | | |
|-------------------------|-------------------------------------|------------------------------------|--|
| Consultant in Charge | | | |
| Operating Surgeon | | | |
| Operating Surgeon Grade | Consultant <input type="checkbox"/> | SPR/ST3-8 <input type="checkbox"/> | F1-ST2 <input type="checkbox"/> Specialty Doctor/SAS <input type="checkbox"/> Other <input type="checkbox"/> |
| First Assistant Grade | Consultant <input type="checkbox"/> | Other <input type="checkbox"/> | |

KNEE PRIMARY PROCEDURE DETAILS

| | | | | | | | |
|---|---|---|---|---|---|--|--------------------------------|
| Side | Left <input type="checkbox"/> | Right <input type="checkbox"/> | | | | | |
| Indications for Implantation (select all that apply) | Osteoarthritis <input type="checkbox"/> | Avascular Necrosis <input type="checkbox"/> | Other Inflammatory Arthropathy <input type="checkbox"/> | Previous Infection <input type="checkbox"/> | Rheumatoid Arthritis <input type="checkbox"/> | Previous Trauma <input type="checkbox"/> | Other <input type="checkbox"/> |
| PRE OPERATIVE RANGE OF MOVEMENT | | | | | | | |
| Fixed Flexion Deformity (degrees) | Less than 10 <input type="checkbox"/> | 10 to 30 <input type="checkbox"/> | Greater than 30 <input type="checkbox"/> | Not Available <input type="checkbox"/> | | | |
| Flexion (degrees) | Less than 70 <input type="checkbox"/> | 70 to 90 <input type="checkbox"/> | 91 to 110 <input type="checkbox"/> | Greater than 110 <input type="checkbox"/> | Not Available <input type="checkbox"/> | | |

SURGICAL APPROACH

| | |
|--|--|
| Patient Procedure | Primary Total Prosthetic Replacement Using Cement <input type="checkbox"/> Primary Total Prosthetic Replacement Not Using Cement <input type="checkbox"/> Unicondylar Knee Replacement <input type="checkbox"/> Patello-Femoral Knee Replacement <input type="checkbox"/> Primary Total Prosthetic Replacement Not Classified Elsewhere (eg Hybrid) <input type="checkbox"/> |
| Consultant in Charge – Default Technique used? | Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, ensure the relevant Surgeon Default Technique is recorded on the Data Entry system. The Surgeon's Default Technique is made up of several data fields. |
| Approach | Medial Parapatellar <input type="checkbox"/> Mid-Vastus <input type="checkbox"/> Lateral Parapatellar <input type="checkbox"/> Other <input type="checkbox"/> Sub-Vastus <input type="checkbox"/> |
| Minimally Invasive Technique Used? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Computer Guided Surgery Used? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

THROMBOPROPHYLAXIS REGIME (intention to treat)

| | |
|------------|---|
| Chemical | Aspirin <input type="checkbox"/> Warfarin <input type="checkbox"/> None <input type="checkbox"/> LMWH <input type="checkbox"/> Direct Thrombin Inhibitor <input type="checkbox"/> Pentasaccharide <input type="checkbox"/> Other <input type="checkbox"/> |
| Mechanical | Foot Pump <input type="checkbox"/> Other <input type="checkbox"/> Intermittent Calf Compression <input type="checkbox"/> None <input type="checkbox"/> TED Stockings <input type="checkbox"/> |

BONEGRAFT USED

| | |
|-------|--|
| Femur | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Tibia | Yes <input type="checkbox"/> No <input type="checkbox"/> |

SURGEON'S NOTES

INTRA OPERATIVE EVENT

| | |
|--------------------------------|--|
| Untoward Intra Operative Event | None <input type="checkbox"/> Ligament Injury <input type="checkbox"/> Fracture <input type="checkbox"/> Other <input type="checkbox"/> Patella Tendon Avulsion <input type="checkbox"/> |
|--------------------------------|--|

Minimum Dataset Form - COMPONENT LABELS

1. Please affix any component labels to this sheet and ensure any extra component label sheets are attached to the main Minimum Dataset Form.
2. Ensure all component details are provided, including cement.
3. The NJR DOES NOT record the following: wire, mesh, cables, plates, screws, surgical tools, endoprotheses or bipolar heads.