



H2

**Hip Single Stage Revision
Hip Stage 1 of 2 Stage Revision
Hip Stage 2 of 2 Stage Revision
Hip Excision Arthroplasty**

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"/>	

HIP REVISION PROCEDURE DETAILS

Procedure Type	Single Stage Revision	<input type="checkbox"/>	Stage 2 of 2 Stage Revision	<input type="checkbox"/>	
	Stage 1 of 2 Stage Revision	<input type="checkbox"/>	Excision Arthroplasty	<input type="checkbox"/>	
Side	Left	<input type="checkbox"/>	Right	<input type="checkbox"/>	
Indications For / Findings at Time of Revision		Stem	Socket	Head	
	Aseptic Loosening	<input type="checkbox"/>	<input type="checkbox"/>	-	
	Implant Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Head/Socket Mismatch	-	<input type="checkbox"/>	<input type="checkbox"/>	
	Lysis	<input type="checkbox"/>	<input type="checkbox"/>	-	
	Malalignment	<input type="checkbox"/>	<input type="checkbox"/>	-	
	Peri-Prosthetic Fracture	<input type="checkbox"/>	<input type="checkbox"/>	-	
	Dislocation/Subluxation	<input type="checkbox"/>	Wear of Acetabular Component		<input type="checkbox"/>
	Infection	<input type="checkbox"/>	Dissociation of Liner		<input type="checkbox"/>
	Pain	<input type="checkbox"/>	Adverse Soft Tissue Reaction to Particulate Debris		<input type="checkbox"/>
		Other		<input type="checkbox"/>	

PRIMARY OPERATION DETAILS

Primary Operation Date OR Year	DD/MM/YYYY	Please enter Date if known	Not Available	<input type="checkbox"/>
Primary Operation Hospital			Not Available	<input type="checkbox"/>

COMPONENTS REMOVED (Do not complete for Stage 2 of 2 Stage Revision)

Femoral Stem Removed	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Brand	Not Available	<input type="checkbox"/>
Acetabular Cup Removed	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Brand	Not Available	<input type="checkbox"/>

SURGICAL APPROACH (Used for Single Stage Revision & Stage 2 of 2 Stage Revision)

Patient Procedure	Revision Using Cement	<input type="checkbox"/>		
	Revision Not Using Cement	<input type="checkbox"/>		
	Revision of and to Resurfacing Arthroplasty	<input type="checkbox"/>		
	Revision Not Classified Elsewhere (eg Hybrid)	<input type="checkbox"/>		
Patient Position	Lateral	<input type="checkbox"/>	Supine	<input type="checkbox"/>
Approach	Hardinge	<input type="checkbox"/>	Extended Trochanteric Osteotomy	<input type="checkbox"/>
	Posterior	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Trochanteric Osteotomy	<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"/>
Acetabulum	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

SURGEON'S NOTES

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INTRA OPERATIVE EVENT

Untoward Intra Operative Event	None	<input type="checkbox"/>	Shaft Fracture	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Calcar Crack	<input type="checkbox"/>	Shaft Penetration	<input type="checkbox"/>		
	Pelvic Penetration	<input type="checkbox"/>	Trochanteric Fracture	<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.