



H2

Hip Single Stage Revision
Hip Stage 1 of 2 Stage Revision
Hip Stage 2 of 2 Stage Revision
Hip Excision Arthroplasty
Insertion of PLAD/Stabiliser
Debridement and Implant Retention (DAIR)

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.

Patient Addressograph

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

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

PATIENT IDENTIFIERS

Forename(s)			
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 or National Patient Identifier (if available)			
Patient Hospital ID			

OPERATION DETAILS

Hospital					
Operation Date	DD/MM/YYYY				
Anaesthetic Types	General <input type="checkbox"/>	<input type="checkbox"/>	Regional – Nerve Block <input type="checkbox"/>	<input type="checkbox"/>	
	Regional - Epidural <input type="checkbox"/>	<input type="checkbox"/>	Regional – Spinal (Intrathecal) <input type="checkbox"/>	<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 (includes modular exchange for indications other than infection) Stage 1 of 2 Stage Revision	<input type="checkbox"/> <input type="checkbox"/>	Stage 2 of 2 Stage Revision Excision Arthroplasty Debridement and implant retention (DAIR)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Revision of	Primary Total Arthroplasty Previous Revision Arthroplasty (excluding excision arthroplasty)	<input type="checkbox"/> <input type="checkbox"/>				
Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>				
Indications For / Findings at Time of Revision	Aseptic Loosening Implant Fracture Head/Socket Mismatch Lysis Malalignment Peri-Prosthetic Fracture	Stem <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Socket <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Head - <input type="checkbox"/> <input type="checkbox"/> - - -		
	Dislocation/Subluxation Infection Unexplained Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Wear of Acetabular Component Dissociation of Liner Adverse Soft Tissue Reaction to Particulate Debris Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

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

COMPONENTS REMOVED (Do not complete for Stage 2 of 2 Stage Revision)			
Femoral Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Modular Head Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Femoral Cement Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Applicable <input type="checkbox"/>
Acetabular Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Acetabular Liner Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Acetabular Cement Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

SURGICAL APPROACH (Used for Single Stage, Stage 2 of 2 Stage Revision & DAIR)					
Patient Procedure	Revision Using Cement Revision Not Using Cement Revision of and to Resurfacing Arthroplasty Debridement And Implant Retention (DAIR) with Modular Exchange Debridement And Implant Retention (DAIR) without Modular Exchange Application Posterior Lip Augmentation Device (PLAD) Modular Exchange for indications other than infection Revision Not Classified Elsewhere (e.g. Hybrid)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Patient Position	Lateral <input type="checkbox"/>	Supine <input type="checkbox"/>			
Approach	Hardinge Posterior Trochanteric Osteotomy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Extended Trochanteric Osteotomy Direct Anterior Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
THROMBOPROPHYLAXIS REGIME (intention to treat)					
Chemical (In Hospital)	Aspirin LMWH Pentasaccharide (e.g. Fondaparinux) Warfarin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Direct Thrombin Inhibitor (e.g. Dabigatran) Factor Xa Inhibitor (e.g. Rivaroxaban/Apixaban) Other None	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mechanical	Foot Pump Intermittent Calf Compression TED Stockings	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other None	<input type="checkbox"/> <input type="checkbox"/>	

BONE GRAFT USED (Not applicable for DAIR procedures, i.e. DAIR <u>with</u> or <u>without</u> modular exchange)				
Was Femoral Bone graft Used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Femoral - Form	Structural <input type="checkbox"/>	Morsellised/chips <input type="checkbox"/>		
Femoral - Type	Autograft <input type="checkbox"/>	Allograft <input type="checkbox"/>	Synthetic <input type="checkbox"/>	Other <input type="checkbox"/>
Was Acetabular Bone graft Used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Acetabular - Form	Structural <input type="checkbox"/>	Morsellised/chips <input type="checkbox"/>		
Acetabular - Type	Autograft <input type="checkbox"/>	Allograft <input type="checkbox"/>	Synthetic <input type="checkbox"/>	Other <input type="checkbox"/>
SURGEON'S NOTES				
<div></div>				

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

<div>1. Please affix any component labels to this sheet and ensure any extra component label sheets are attached to the main Minimum Dataset Form.</div> <div>2. Ensure all component details are provided, including cement.</div> <div>3. The NJR DOES NOT record the following: wire, mesh, cables, plates, screws, surgical tools, endoprotheses or bipolar heads.</div>	
Cup or Shell	Liner (if used)
Stem	Head
Cement (if used)	Accessories (not screws)