



E2

Elbow Single Stage Revision
Elbow Stage 1 of 2 Stage Revision
Elbow Stage 2 of 2 Stage Revision
Failed Hemi-arthroplasty
Conversion to Arthrodesis
Excision Arthroplasty
Amputation

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 ☐

No ☐

Not Recorded ☐

Patient Hospital ID

Handedness

Left ☐

Right ☐

Ambidextrous ☐

PATIENT IDENTIFIERS

Forename

Surname

Gender

Male ☐

Female ☐

Not Known ☐

Not Specified ☐

Date of Birth

DD/MM/YYYY

Patient Postcode

Overseas Address ☐

NHS or National Patient Number (if available)

OPERATION DETAILS

Hospital

Operation Date

DD/MM/YYYY

Anaesthetic Types

General ☐

Regional – Epidural ☐

Regional – Nerve Block ☐

Patient ASA Grade

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

Operation Funding

NHS ☐

Independent ☐

SURGEON DETAILS

Consultant in Charge

Operating Surgeon

Operating Surgeon Grade

Consultant ☐

SpR/ST3-8 ☐

F1-ST2 ☐

Specialty Doctor/SAS ☐

Other ☐

First Assistant Grade

Consultant ☐

Other ☐

ELBOW REVISION PROCEDURE DETAILS				
Procedure Type	Single Stage Revision	<input type="checkbox"/>	Conversion to Arthrodesis	<input type="checkbox"/>
	Stage 1 of 2 Stage Revision	<input type="checkbox"/>	Excision Arthroplasty	<input type="checkbox"/>
	Stage 2 of 2 Stage Revision	<input type="checkbox"/>	Amputation	<input type="checkbox"/>
Revision of	Primary Arthroplasty	<input type="checkbox"/>	Previous Revision Arthroplasty (excluding excision arthroplasty)	<input type="checkbox"/>
Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>		
Indications For / Findings at Time of Revision (select all that apply)	Infection	<input type="checkbox"/>	Periprosthetic Fracture	<input type="checkbox"/>
	Instability	<input type="checkbox"/>	Failed Hemi-arthroplasty	<input type="checkbox"/>
	Aseptic Loosening	<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)			
* 'Not Applicable' indicates that the component was not present.			
Radial Component Removed	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable* <input type="checkbox"/>	Brand	Not Available <input type="checkbox"/>
Humeral Component Removed	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable* <input type="checkbox"/>	Brand	Not Available <input type="checkbox"/>
Ulnar Component Removed	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable* <input type="checkbox"/>		

SURGICAL APPROACH (Used for Single Stage Revision & Stage 2 of 2 Stage Revision)			
Patient Procedure	Revision Total Prosthetic Replacement	<input type="checkbox"/>	
	Revision Radial Head Replacement	<input type="checkbox"/>	
	Revision to Lateral Resurfacing	<input type="checkbox"/>	
Fixation Type	Cementless <input type="checkbox"/>	Cemented <input type="checkbox"/>	Hybrid <input type="checkbox"/>
Approach	Kocher	<input type="checkbox"/>	
	Posterior	<input type="checkbox"/>	

THROMBOPROPHYLAXIS REGIME (intention to treat)				
Chemical (In Hospital)	Aspirin	<input type="checkbox"/>	Direct Thrombin Inhibitor	<input type="checkbox"/>
	LMWH	<input type="checkbox"/>	(eg Dabigatran)	
	Pentasaccharide (eg Fondaparinux)	<input type="checkbox"/>	Factor Xa Inhibitor (eg Rivaroxaban/Apixaban)	<input type="checkbox"/>
	Warfarin	<input type="checkbox"/>	Other	<input type="checkbox"/>
			None	<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"/>		

BONE GRAFT USED	
Humeral Bone Graft	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulnar Bone Graft	Yes <input type="checkbox"/> No <input type="checkbox"/>

SURGEON'S NOTES	
<div></div>	

INTRA OPERATIVE EVENT				
Untoward Intra Operative Event	None	<input type="checkbox"/>	Fracture Ulna	<input type="checkbox"/>
	Shaft Penetration Humerus	<input type="checkbox"/>	Nerve Injury	<input type="checkbox"/>
	Shaft Penetration Ulna	<input type="checkbox"/>	Vascular Injury	<input type="checkbox"/>
	Fracture Humerus	<input type="checkbox"/>	Other	<input type="checkbox"/>

None
Shaft Penetration Humerus
Shaft Penetration Ulna
Fracture Humerus

☐
☐
☐
☐

Other

☐
☐
☐
☐

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, surgical tools or endoprotheses.

Ulnar Component (if used)

Humeral component

Radial component (if used)
Required for hemi-arthroplasty

Cement (if used)

Accessories