



National Joint Registry

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Working for patients, driving forward quality

MDS VERSION 7.0 Knee Operation

Form: MDSv7.0 K1 v2.0

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

NJR Patient Consent Obtained

Yes ☐

No ☐

Not Recorded ☐

Body Mass Index
(enter either H&W OR BMI OR
tick Not Available box)

Height (IN M)

Weight (IN KG)

BMI

Not Available ☐

PATIENT IDENTIFIERS

Forename(s)

Surname

Gender

Male ☐

Female ☐

Not Known ☐

Not Specified ☐

Date of Birth

DD/MM/YYYY

Patient Postcode

Overseas Address ☐

NHS Number or National Patient
Identifier (if available)

Patient Hospital ID

OPERATION DETAILS

Hospital

Operation Date

DD/MM/YYYY

Anaesthetic Types

General ☐

Regional - Epidural ☐

Regional – Nerve Block ☐

Regional – Spinal (Intrathecal) ☐

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 ☐

KNEE PRIMARY PROCEDURE DETAILS									
Side	Left <input type="checkbox"/>		Right <input type="checkbox"/>						
Indications for Implantation (select all that apply)	Osteoarthritis		<input type="checkbox"/>		Rheumatoid Arthritis		<input type="checkbox"/>		
	Avascular Necrosis (AVN)		<input type="checkbox"/>		Previous Trauma		<input type="checkbox"/>		
	Other Inflammatory Arthropathy		<input type="checkbox"/>		Other		<input type="checkbox"/>		
	Previous Infection		<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"/>				
	Unicompartmental Knee Replacement (select all that apply)				<input type="checkbox"/>				
	Medial <input type="checkbox"/>		Lateral <input type="checkbox"/>		Patello-Femoral <input type="checkbox"/>				
	Primary Total Prosthetic Replacement Not Classified Elsewhere (e.g. Hybrid)				<input type="checkbox"/>				
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"/>						
Patient Specific Instruments?	Yes <input type="checkbox"/>		No <input type="checkbox"/>						
THROMBOPROPHYLAXIS REGIME (intention to treat)									
Chemical (In Hospital)	Aspirin		<input type="checkbox"/>		Direct Thrombin Inhibitor (e.g. Dabigatran)		<input type="checkbox"/>		
	LMWH		<input type="checkbox"/>		Factor Xa Inhibitor (e.g. Rivaroxaban/Apixaban)		<input type="checkbox"/>		
	Pentasaccharide (e.g. Fondaparinux)		<input type="checkbox"/>		Other		<input type="checkbox"/>		
	Warfarin		<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									
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 Tibial Bone graft used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>						
Tibial - Form	Structural <input type="checkbox"/>		Morsellised/chips <input type="checkbox"/>						
Tibial - Type	Autograft <input type="checkbox"/>		Allograft <input type="checkbox"/>		Synthetic <input type="checkbox"/>		Other <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.

Femoral Component (or unicondylar femoral component)

Tibial Tray (or unicondylar tibial component)

Meniscal Component

Cement (if used)

Patella (if used) Needed in Patello-femoral replacement

Accessories