

Data Entry Form

Patient Details	
Hospital Number	
BMI Calculation	Weight (Kg): Height(metres):
Surname	
Other Names	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	DD/MM/YY
Passport/ ID Number	

Operation Details	
Hospital TJR Code	
Surgeon TJR Code	
Operation Date	DD/MM/YY
Anaesthetic Type (Tick one)	<input type="checkbox"/> General Regional: <input type="checkbox"/> Epidural <input type="checkbox"/> Spinal <input type="checkbox"/> Combined Spinal Epidural <input type="checkbox"/> Nerve block
Surgery (Tick one)	<input type="checkbox"/> Primary Cemented Total Hip Arthroplasty <input type="checkbox"/> Primary Non Cemented Total Hip Arthroplasty <input type="checkbox"/> Primary Hybrid Total Hip Arthroplasty <input type="checkbox"/> Primary Total Knee Arthroplasty

	<input type="checkbox"/> Revision Total Hip Arthroplasty <input type="checkbox"/> Revision Total Knee Arthroplasty
Side	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral
Surgery indications (tick)	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inflammatory Arthropathy <input type="checkbox"/> Congenital Dislocation / Dysplasia of the Hip <input type="checkbox"/> Avascular Necrosis <input type="checkbox"/> Trauma – Acute (Neck of Femur) <input type="checkbox"/> Failed Hemi-Arthroplasty <input type="checkbox"/> Trauma – Chronic <input type="checkbox"/> Previous total joint Surgery <input type="checkbox"/> Previous Arthrodesis <input type="checkbox"/> Previous Infection <input type="checkbox"/> Other
Patient Position	<input type="checkbox"/> Lateral <input type="checkbox"/> Supine
Total Hip Approach	<input type="checkbox"/> Lateral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior
Thromboprophylaxis	
Chemical	<input type="checkbox"/> None <input type="checkbox"/> Aspirin <input type="checkbox"/> LMWH <input type="checkbox"/> Pentasaccharide <input type="checkbox"/> Warfarin <input type="checkbox"/> Direct Thrombin Inhibitor <input type="checkbox"/> Other
Mechanical	<input type="checkbox"/> None <input type="checkbox"/> TED Stockings <input type="checkbox"/> Foot Pump <input type="checkbox"/> Intermittent Calf Compression <input type="checkbox"/> Other

Implant details	
Total Knee Implant Name	
Component sizes	Femoral: Tibial Tray:
	Patella: Tibial Insert:
Total Hip Implant Name	
Component sizes	Femoral Stem: Acetabular Shell:
	Femoral Head: Acetabular Cup/Liner:

Intraoperative Complications	
<i>Total Hip Replacement</i>	<i>Total Knee Replacement</i>
<input type="checkbox"/> None <input type="checkbox"/> Calcar crack <input type="checkbox"/> Shaft Fracture <input type="checkbox"/> Shaft Penetration <input type="checkbox"/> Trochanteric Fracture <input type="checkbox"/> Other:	<input type="checkbox"/> None <input type="checkbox"/> Fracture <input type="checkbox"/> Patella tendon avulsion <input type="checkbox"/> Ligament injury <input type="checkbox"/> Other: