



Place **PATIENT DETAILS** label here

and/or

if any patient details are not available on the hospital label please complete below

Surname: Female: Male:
First Name: Middle Initial:
Address:
..... Post Code:
Hospital Patient No: DOB:/...../.....
Medicare No: DVA No:
NHI (NZ): ACC No (NZ):

Name of Hospital: State/Region:
Surgeon Name:

Weight (kg)..... Height (cm)..... ASA.....

PLEASE COMPLETE THIS SECTION IN FULL

(IF BILATERAL USE **TWO** FORMS)

OPERATION DATE/...../.....

L **R**

PRIMARY TMJ

REVISION TMJ

includes removal, exchange or addition of one or more components

DIAGNOSIS (Tick one)

Osteoarthritis
Rheumatoid Arthritis
Ankylosis Fibrous
Bony.....
Tumour *specify*
.....
Other *specify*
.....

DIAGNOSIS (Tick more than one box if applicable)

Loosening
Lysis
Infection.....
Implant Breakage Condylar.....
Fossa.....
Other *specify*
.....

PRE-OP INFORMATION

Maxilla (tick one)

Dentate..... Edentulous.....

Mandible (tick one)

Dentate..... Edentulous.....

Jaw Relation (tick one)

Class 1..... Class 2..... Class 3.....

Previous TMJ Surgery No..... Yes.....

If yes, specify number of previous surgeries.....

Facial Nerve Injury No..... Yes.....

If yes, specify level (select all that apply) I..... II..... III..... IV.....

Mouth Opening (in millimetres).....

Preliminary surgery required to place implant No..... Yes.....
(i.e. 2 stage procedure)

VAS Pain Scale result (0-10): (tick one)

0... | 1... 2... 3... 4... 5... 6... | 7... 8... 9... 10...
Mild Moderate Severe

COINCIDENTAL SURGERY WITH ALLOPLAST

Not Applicable.....

Grafts (Select all that apply)

Fat graft..... Muscle graft..... Other (specify).....

Osteotomy (Tick one)

Mandible..... Maxilla..... Bimaxillary.....



CONDYLAR COMPONENTS

(Mark relevant box, place company labels on coloured areas or complete details by hand)

Company

Prosthesis Name

Cat/Ref No.

Lot No.

Company

Prosthesis Name

Cat/Ref No.

Lot No.

CONDYLAR COMPONENT SCREW

NUMBER.....

Minimum Length (mm)..... Maximum Length (mm).....

FOSSA COMPONENTS

(Mark relevant box, place company labels on coloured areas or complete details by hand)

Company

Prosthesis Name

Cat/Ref No.

Lot No.

Company

Prosthesis Name

Cat/Ref No.

Lot No.

FOSSA COMPONENT SCREW

NUMBER.....

Minimum Length (mm)..... Maximum Length (mm).....

TECHNOLOGY ASSISTED *(tick all that apply)*

Computer Navigated..... **NO** **YES**

System used:

Image Derived Instrumentation (IDI)..... **NO** **YES**

System used:

ADDITIONAL COMMENTS (or Extra Labels)

ALL SECTIONS of this form MUST be COMPLETED