



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.
 (If applicable)

Name of Hospital: State:
 Consultant Surgeon Code:

Weight (kg) Height (cm) ASA

PLEASE COMPLETE THIS SECTION IN FULL

(IF BILATERAL USE **TWO** FORMS)

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

L **R**

PRIMARY KNEE

includes primary partial or total knee replacement

UNICOMPARTMENTAL Indicate Medial
 Lateral

DIAGNOSIS

Osteoarthritis
 Rheumatoid Arthritis
 Other Inflammatory Arthritis
 Osteonecrosis/Avascular Necrosis
 Tumour *specify*

 Other *specify*

REVISION KNEE

includes removal, exchange or addition of one or more components

UNICOMPARTMENTAL Indicate Medial
 Lateral

DIAGNOSIS (Tick more than one box if applicable)

Loosening
 Lysis
 Infection.....
 Implant Breakage *specify* Femoral
 Tibial
 Patella
 Fracture *specify*
 Other *specify*

FEMORAL COMPONENTS

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

NONE FEMORAL STEM

Company
 Prosthesis Name
 Cat/Ref No.
 Lot No.

Company
 Prosthesis Name
 Cat/Ref No.
 Lot No.

FEMORAL CEMENT

NO YES

See over for tibial or patella cement

CEMENT NAME:

(Use company label or complete details: if more than one mix is used, use only 1 label)

FEMORAL SPACERS

(Complete details by marking boxes)

NONE

DISTAL FEMORAL Medial Lateral

POSTERIOR CONDYLE Medial Lateral



TIBIAL COMPONENTS

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

NONE ALL-IN-ONE BASE PLATE INSERT STEM

Company

Prosthesis Name

Cat/Ref No.

Lot No.

Company

Prosthesis Name

Cat/Ref No.

Lot No.

Company

Prosthesis Name

Cat/Ref No.

Lot No.

TIBIAL CEMENT NO YES

CEMENT NAME:

(Use company label or complete details: if more than one mix is used, use only 1 label)

TIBIAL SPACERS

(Complete details by marking boxes)

NONE **BLOCKS** Medial Lateral

WEDGES Medial Lateral

SCREWS NO YES Number

PATELLA COMPONENT

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

NONE YES

Company

Prosthesis Name

Cat/Ref No.

Lot No.

PATELLA CEMENT NO YES

CEMENT NAME:

(Use company label or complete details: if more than one mix is used, use only 1 label)

COMPUTER NAVIGATED/ROBOTICS NO YES

System used:

IMAGE DERIVED INSTRUMENTATION (IDI) NO YES

(Affix label here)

ADDITIONAL COMMENTS (or Extra Labels)

ALL SECTIONS of this form MUST be COMPLETED