TMJ Registry
TEMPOROMANDIBULAR JOINT FORM

Australian Orthopaedic Association
National Joint Replacement Registry

AUS / NZ

SIDE 1

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 ..... ☐

Boney..... ☐

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..... ☐

Australia- *Please return form to* **AOANJRR, Locked Bag 2, Hutt St Post Office, Adelaide, SA, Australia 5000**

Please complete Side 2

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