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 TAR ☐

PRIMARY ARTHRODESIS ☐

REVISION/RE-OPERATION ☐
(if revision/re-operation ticked please complete the COFAS reoperation code)

DIAGNOSIS (Tick more than one box if applicable)

- Osteoarthritis ☐
- Post Traumatic Arthritis ☐
- Rheumatoid Arthritis ☐
- Other Inflammatory Arthritis ☐
- Fracture *specify* ☐
- Instability ☐
- Malalignment ☐
- Other *specify* ☐

DIAGNOSIS (Tick more than one box if applicable)

- Loosening ☐
- Lysis ☐
- Infection ☐
- Implant Breakage *specify* ☐
- Instability ☐
- Dislocation ☐
- Component Dissociation ☐
- Fracture *specify* ☐
- Non-Union of arthrodesis ☐
- Mal-Union of arthrodesis ☐
- Other *specify* ☐

PRE-OP XR TALAR TILT: MORTISE VIEW ANKLE & LATERAL TIBIAL LINE

Please complete this section for TAR and Arthrodesis

Valgus Varus Neither *(Primary only - Circle one above)* Angle ..... *(Write degrees above)* ° Degree

(Scan for Guide)

Pre op COFAS Type: *(Circle one)* 1 2 3 4 5a 5b 5c 6

COFAS reoperation code: *(Circle one)* 2 3 4 5 6 7 8 9 10 11 12 13

Previous Procedures **NO** ☐ **YES** ☐

- Planovalgus Reconstruction ..... NO ☐ YES ☐
- Cavovarus Reconstruction ..... NO ☐ YES ☐
- Supramalleolar Osteotomy ..... NO ☐ YES ☐
- TAR NO ☐ YES ☐ Type/Brand:.....
- Arthrodesis NO ☐ YES ☐ Joint Fused:.....

Fracture Fixation *(Tick all that apply)* NO ☐ YES ☐

- One Malleolus ..... ☐ >1 Malleolus ..... ☐
- Pilon / Talus Fracture ..... ☐ Syndesmosis ..... ☐

Concurrent Surgeries *(Tick all that apply)* **NO** ☐ **YES** ☐

- Achilles Lengthening ..... NO ☐ YES ☐
- Ligament Stabilization ..... NO ☐ Medial ☐ Lateral ☐
- Hindfoot Reconstruction ..... NO ☐ Osteotomy ☐ Arthrodesis ☐
- Forefoot / Midfoot Reconstruction ..... NO ☐ Osteotomy ☐ Arthrodesis ☐
- Other *specify* ..... NO ☐ YES ☐

Arthrodesis **NO** ☐ **YES** ☐ Arthroscopic NO ☐ YES ☐

Fixation Type *(tick all that apply)*

- Screws ..... ☐ IM Nail..... ☐
- Plate ..... ☐ External Fixation ..... ☐
- Other..... ☐

Bone Graft *(tick all that apply)* **NO** ☐ **YES** ☐

- Autograft ..... ☐ Allograft ..... ☐
- Synthetic ..... ☐ Biologic ..... ☐

(Stickers can be placed on reverse of this form)

TIBIAL 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. .....

TALAR 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. .....

CEMENT

TIBIAL **NO** ☐ **YES** ☐

TALAR **NO** ☐ **YES** ☐

CEMENT NAME .....

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

SURGEON ASSISTIVE TOOLS

(Tick all that apply – affix label below if available)

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

ADDITIONAL COMMENTS (or Extra Labels)

.....

ALL SECTIONS of this form MUST be COMPLETED