HIP FORM

Australian Orthopaedic Association
National Joint Replacement Registry

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. ..... (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** ☐

OPERATIVE APPROACH (Tick one box only)

Posterior ☐ Lateral ☐ Anterior ☐ Other *specify*.....

PRIMARY HIP ☐

Includes Unipolar (Austin Moore/Thompson Type), Bipolar or THR

DIAGNOSIS

Osteoarthritis ..... ☐
Rheumatoid Arthritis ..... ☐
Other Inflammatory Arthritis ..... ☐
Osteonecrosis/Avascular Necrosis ..... ☐
Developmental Dysplasia ..... ☐
Fractured Neck of Femur..... ☐
Tumour *specify* ..... ☐
Other *specify* ☐

REVISION HIP ☐

Includes removal, exchange or addition of one or more components

DIAGNOSIS (Tick more than one box if applicable)

Loosening ..... ☐
Lysis ..... ☐
Dislocation ..... ☐
Infection ..... ☐
Implant Breakage Stem ..... ☐
Acetabular ..... ☐
Fracture *specify* ..... ☐
Other *specify* ..... ☐

ACETABULAR COMPONENTS

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

NONE ☐ CUP ☐ SHELL ☐ INSERT ☐ BIPOLAR ☐ REINFORCEMENT RING ☐ MESH ☐

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

ACETABULAR CEMENT **NO** ☐ **YES** ☐

See over for femoral cement

CEMENT NAME: .....

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

(Complete by hand, labels not required)

SCREWS: **NO** ☐ **YES** ☐ **Number used** .....

Please return form to **Locked Bag 2, Hutt St Post Office, ADELAIDE SA 5000**

Please complete Side 2

FEMORAL COMPONENTS

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

NONE ☐ STEM ☐ HEAD ☐ CENTRALISER ☐ INTRAMEDULLARY PLUG ☐

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

FEMORAL CEMENT

NO ☐ **YES** ☐

See over for acetabular cement

CEMENT NAME: .....

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

ADDITIONS

(Use company label for grip and cable and/or complete details)

TROCHANTERIC GRIP: **NO** ☐ **YES** ☐

Company: .....

CABLE/S: (For multiple cables use 1 label) **NO** ☐ **YES** ☐

Number used: ..... **Company:** .....

WIRE: (Complete by hand) ..... **NO** ☐ **YES** ☐

TECHNOLOGY ASSISTED *tick all that apply*

Computer Navigated ..... **NO** ☐ **YES** ☐
System used: .....

Image Derived Instrumentation (IDI)..... **NO** ☐ **YES** ☐
System used: .....

Robotic Assisted ..... **NO** ☐ **YES** ☐
System used: .....
Acetabular only ☐ Both (Femur and Acetabular) ☐

Other ..... **NO** ☐ **YES** ☐
System used: .....

Affix label here if available:

ADDITIONAL COMMENTS (or Extra Labels)

.....

ALL SECTIONS of this form MUST be COMPLETED