SPINAL DISC

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

(COMPLETE A SEPARATE FORM FOR EACH LEVEL)

OPERATION DATE ...../...../..... **LEVEL** .....

PRIMARY ☐

(Tick more than one box if applicable)

DIAGNOSIS

Disc Disease

- With radiculopathy ..... ☐
- Without radiculopathy ..... ☐

Spondylolisthesis ... . ☐

Adjacent segment syndrome ..... ☐

Post laminectomy or discectomy ..... ☐

Adjacent to concurrent fusion ..... ☐

Pain of unknown cause ..... ☐

Other: *specify* ..... ☐

REVISION or REMOVAL ☐

Revision includes: removal, exchange or addition of one or more components
(Tick more than one box if applicable)

DIAGNOSIS

Loosening ..... ☐

Lysis ..... ☐

Dislocation ..... ☐

Infection ..... ☐

Implant Breakage: *specify below* ..... ☐

Fracture: *specify below* ..... ☐

Neurological: *specify below* ..... ☐

Other: *specify below* ..... ☐

.....

COMPONENTS

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

ENDPLATES ☐ **INSERT** ☐ **ONE-PIECE** ☐

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. .....

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

Please complete Side 2

COMPONENTS

(Mark relevant box/es, 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. .....

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

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

FIXATION METHODS

SCREWS: **NO** ☐ **YES** ☐

CEMENT: **NO** ☐ **YES** ☐

CEMENT NAME:

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

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: .....

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

Affix label here if available:

ADDITIONAL COMMENTS (or Extra Labels)

.....

ALL SECTION of this form MUST be COMPLETED