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** ☐

ELBOW ☐ **WRIST** ☐

PRIMARY ☐ **REVISION** ☐ **RE-OPERATION** ☐

Includes removal, exchange or addition of one or more components

See side 2 for re-operation definition

Osteoarthritis	☐	Loosening	☐
Post Traumatic Arthritis	☐	Lysis	☐
Rheumatoid Arthritis	☐	Infection	☐
Other Inflammatory Arthritis	☐	Implant Breakage *specify*	☐
Fracture *specify*	☐	Instability	☐
Osteonecrosis/Avascular Necrosis	☐	Dislocation	☐
Dislocation	☐	Component Dissociation	☐
Instability	☐	Fracture *specify*	☐
Tumour *specify*	☐	Other *specify*	☐
Other *specify*	☐		

PROXIMAL COMPONENTS

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

NONE ☐ ELBOW/Humeral ☐ WRIST/Radial/Ulnar ☐ DRUJ ☐

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. .....

DISTAL COMPONENTS

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

NONE ☐ ELBOW/Radial Head/Ulna ☐ WRIST/Carpus ☐

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

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

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

CEMENT

PROXIMAL **NO** ☐ **YES** ☐
ELBOW/Humeral WRIST/Radial/Ulnar

DISTAL **NO** ☐ **YES** ☐
ELBOW/Ulnar WRIST/Carpal

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

ADDITIONAL PROCEDURE **NO** ☐ **YES** ☐

Bone Graft *(Tick All That Apply)*

Autograft..... ☐ Synthetic..... ☐

Allograft: Strut ☐ Allograft Prosthesis Composite ☐ Soft Tissue Reconstruction ☐

Lot No.....

Additional Fixation ..... **NO** ☐ **YES** ☐

RE-OPERATION

This is an additional operation on a joint that has previously received a prosthesis. A re-operation however, is not a revision. (i.e) IT DOES NOT involve removal, exchange or addition of one or more components. It is usually an isolated soft tissue and/or bony procedure.

Re-operation performed .....

Reason for re-operation .....

Comments (If required)

SURGEON ASSISTIVE TOOLS *tick all that apply*

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

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

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

Affix label here if available:

ADDITIONAL COMMENTS (or Extra Labels)

ALL SECTIONS of this form MUST be COMPLETED