



A1 Ankle Primary

Patient Addressograph

Important:

Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Dataset Form Component Labels Sheet'. Please ensure that all sheets are stapled together.

All fields are Mandatory unless otherwise indicated

REMEMBER! MAKE A NOTE OF THE NJR REFERENCE NUMBER WHEN YOU ENTER THIS DATA

NJR REF:

PATIENT DETAILS

NJR Patient Consent Obtained	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Recorded <input type="checkbox"/>
If 'Yes' or 'No' was selected for patient consent above, was consent provided by a consultee on behalf of the patient?	Yes <input type="checkbox"/>	No/Not Known <input type="checkbox"/>	
Body Mass Index (enter either H&W OR BMI OR tick Not Available box)	Height (IN M) Weight (IN KG)	BMI	Not Available <input type="checkbox"/>

PATIENT IDENTIFIERS

Forename(s)			
Surname			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Not Specified <input type="checkbox"/>
Date of Birth	DD/MM/YYYY		
Patient Postcode		Overseas Address <input type="checkbox"/>	
NHS Number OR National Patient Identifier (if available)			
Patient Hospital ID			
Patient email address (optional)			
Patient mobile phone number (optional)			

OPERATION DETAILS

Hospital			
Operation Date	DD/MM/YYYY		
Anaesthetic Types	General <input type="checkbox"/>	Regional – Nerve Block <input type="checkbox"/>	Regional – Spinal (Intrathecal) <input type="checkbox"/>
	Regional – Epidural <input type="checkbox"/>		
Patient ASA Grade	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Operation Funding	NHS <input type="checkbox"/>	Independent <input type="checkbox"/>	

SURGEON DETAILS	
Consultant in Charge	
Operating Surgeon	
Operating Surgeon Grade	Consultant <input type="checkbox"/> SpR/ST3-8 <input type="checkbox"/> F1-ST2 <input type="checkbox"/> Specialty Doctor/SAS <input type="checkbox"/> Other <input type="checkbox"/>
First Assistant Grade	Consultant <input type="checkbox"/> Other <input type="checkbox"/>

ANKLE PRIMARY PROCEDURE DETAILS	
Side	Left <input type="checkbox"/> Right <input type="checkbox"/>
Indications for Implantation (select all that apply)	Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other Inflammatory Arthropathy <input type="checkbox"/> Other <input type="checkbox"/>
Has the patient had a previous fracture around the index joint?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not available <input type="checkbox"/>
Previous Surgery on Index Joint (select all that apply)	None <input type="checkbox"/> Internal Fixation <input type="checkbox"/> Other <input type="checkbox"/> Distal Tibial Osteotomy <input type="checkbox"/> Arthrodesis <input type="checkbox"/> Not Available <input type="checkbox"/>
Has the patient had a previous bony infection of the tibia or hindfoot	Yes <input type="checkbox"/> No <input type="checkbox"/> Not available <input type="checkbox"/>
PRE-OPERATIVE RANGE DEFORMITY	
Tibia-Hindfoot Alignment (based on clinical assessment)	Physiological Neutral <input type="checkbox"/> Not Available <input type="checkbox"/> 5-15° Varus <input type="checkbox"/> 16-30° Varus <input type="checkbox"/> >30 Varus <input type="checkbox"/> 5-15° Valgus <input type="checkbox"/> 16-30° Valgus <input type="checkbox"/> >30 Valgus <input type="checkbox"/>
PRE-OPERATIVE RANGE OF MOVEMENT (Clinical)	
Ankle Dorsiflexion (degrees)	5-20° <input type="checkbox"/> Neutral <input type="checkbox"/> Fixed Equinus <input type="checkbox"/> Not Available <input type="checkbox"/>
Ankle Plantarflexion (degrees)	5-15° <input type="checkbox"/> 16-45° <input type="checkbox"/> Not Available <input type="checkbox"/>
Subtalar Joint	Normal ROM (compared to opp side) <input type="checkbox"/> Stiff (compared to opp side) <input type="checkbox"/> Not Available <input type="checkbox"/> Joint has been fused <input type="checkbox"/>

SURGICAL APPROACH	
Patient Procedure	Primary Total Prosthetic Replacement Not Using Cement <input type="checkbox"/> Primary Total Prosthetic Replacement Using Cement <input type="checkbox"/> Primary Total Prosthetic Replacement Not Classified Elsewhere (e.g. Hybrid) <input type="checkbox"/>
Approach	Anterior <input type="checkbox"/> Anterolateral <input type="checkbox"/> Lateral (transfibular) <input type="checkbox"/> Other <input type="checkbox"/>
Associated Procedures at the time of surgery* (select all that apply) <small>*Also select if previously carried out or procedures are planned at the time of index surgery</small>	Subtalar Joint Fusion <input type="checkbox"/> Medial Malleolar Osteotomy <input type="checkbox"/> Talonavicular Fusion <input type="checkbox"/> Lateral Ligament Reconstruction <input type="checkbox"/> Calcaneal Displacement Osteotomy <input type="checkbox"/> Medial Ligament Reconstruction <input type="checkbox"/> Achilles Tendon Lengthening <input type="checkbox"/> Medial Ligament release <input type="checkbox"/> Fusion Distal Tibiofibular Joint <input type="checkbox"/> Other <input type="checkbox"/> Fibula Osteotomy <input type="checkbox"/> None <input type="checkbox"/>
Computer Guided Surgery Used?	Yes <input type="checkbox"/> No <input type="checkbox"/>
THROMBOPROPHYLAXIS REGIME (intention to treat)	
Chemical (In Hospital)	Aspirin <input type="checkbox"/> Direct Thrombin Inhibitor (e.g. Dabigatran) <input type="checkbox"/> LMWH <input type="checkbox"/> Factor Xa Inhibitor (e.g. Rivaroxaban/Apixaban) <input type="checkbox"/> Pentasaccharide (e.g. Fondaparinux) <input type="checkbox"/> Other <input type="checkbox"/> Warfarin <input type="checkbox"/> None <input type="checkbox"/>
Mechanical	Foot Pump <input type="checkbox"/> Other <input type="checkbox"/> Intermittent Calf Compression <input type="checkbox"/> None <input type="checkbox"/> TED Stockings <input type="checkbox"/>

BONE GRAFT USED								
Was Tibial Bone graft used?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				
Tibial – Form	Structural	<input type="checkbox"/>	Morsellised/chips	<input type="checkbox"/>				
Tibial – Type	Autograft	<input type="checkbox"/>	Allograft	<input type="checkbox"/>	Synthetic	<input type="checkbox"/>	Other	<input type="checkbox"/>
Was Talar Bone graft used?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				
Talar – Form	Structural	<input type="checkbox"/>	Morsellised/chips	<input type="checkbox"/>				
Talar – Type	Autograft	<input type="checkbox"/>	Allograft	<input type="checkbox"/>	Synthetic	<input type="checkbox"/>	Other	<input type="checkbox"/>
Was Fibular Bone graft used?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				
Fibular - Form	Structural	<input type="checkbox"/>	Morsellised/chips	<input type="checkbox"/>				
Fibular - Type	Autograft	<input type="checkbox"/>	Allograft	<input type="checkbox"/>	Synthetic	<input type="checkbox"/>	Other	<input type="checkbox"/>

SURGEON'S NOTES

INTRA-OPERATIVE EVENT				
Untoward Intra-Operative Event (select all that apply)	None	<input type="checkbox"/>	Ligament Injury	<input type="checkbox"/>
	Fracture medial malleolus	<input type="checkbox"/>	Nerve injury	<input type="checkbox"/>
	Fracture lateral malleolus	<input type="checkbox"/>	Tendon injury	<input type="checkbox"/>
	Fracture (other)	<input type="checkbox"/>	Other	<input type="checkbox"/>

Minimum Dataset Form - COMPONENT LABELS

1. Please affix any component labels to this sheet and ensure any extra component label sheets are attached to the main Minimum Dataset Form.
2. Ensure all component details are provided, including cement.
3. The NJR DOES NOT record the following: wire, mesh, cables, plates, screws, surgical tools, endoprosthesis or bipolar heads.

Talar Component

Tibial tray component

Meniscal component

Cement (if used)

Accessories