



H2

Hip Single Stage Revision
Hip Stage 1 of 2 Stage Revision
Hip Stage 2 of 2 Stage Revision
Hip Excision Arthroplasty
Insertion of PLAD/Stabiliser
Debridement and Implant Retention (DAIR)

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 - Epidural <input type="checkbox"/>	Regional - Spinal (Intrathecal) <input type="checkbox"/>
Patient ASA Grade	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <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"/>			

HIP REVISION PROCEDURE DETAILS

Procedure Type	Single Stage Revision (includes modular exchange for indications other than infection) <input type="checkbox"/> Stage 1 of 2 Stage Revision <input type="checkbox"/>		Stage 2 of 2 Stage Revision Excision Arthroplasty <input type="checkbox"/> Debridement and implant retention (DAIR) <input type="checkbox"/>	
Revision of	Primary Total Arthroplasty <input type="checkbox"/>		Previous Revision Arthroplasty (excluding excision arthroplasty) <input type="checkbox"/>	
Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>		
Indications For / Findings at Time of Revision	Aseptic Loosening	Stem <input type="checkbox"/>	Socket <input type="checkbox"/>	Head -
	Implant Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Head/Socket Mismatch	-	<input type="checkbox"/>	<input type="checkbox"/>
	Lysis	<input type="checkbox"/>	<input type="checkbox"/>	-
	Malalignment	<input type="checkbox"/>	<input type="checkbox"/>	-
	Peri-Prosthetic Fracture	<input type="checkbox"/>	<input type="checkbox"/>	-
	Dislocation/Subluxation <input type="checkbox"/>	<input type="checkbox"/>	Wear of Acetabular Component <input type="checkbox"/>	<input type="checkbox"/>
	Infection <input type="checkbox"/>	<input type="checkbox"/>	Dissociation of Liner <input type="checkbox"/>	<input type="checkbox"/>
	Unexplained Pain <input type="checkbox"/>	<input type="checkbox"/>	Adverse Soft Tissue Reaction to Particulate Debris <input type="checkbox"/>	<input type="checkbox"/>
			Other <input type="checkbox"/>	<input type="checkbox"/>

PREVIOUS OPERATION DETAILS

Previous Operation Date OR Year	DD/MM/YYYY	Please enter Date if known	Not Available <input type="checkbox"/>
Previous Operation Hospital			Not Available <input type="checkbox"/>

COMPONENTS REMOVED (Do not complete for Stage 2 of 2 Stage Revision)

Femoral Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Modular Head Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Femoral Cement Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Applicable <input type="checkbox"/>
Acetabular Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Acetabular Liner Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Acetabular Cement Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

SURGICAL APPROACH (Used for Single Stage, Stage 2 of 2 Stage Revision & DAIR)

Patient Procedure	Revision Using Cement <input type="checkbox"/> Revision Not Using Cement <input type="checkbox"/> Revision of and to Resurfacing Arthroplasty <input type="checkbox"/> Debridement And Implant Retention (DAIR) with Modular Exchange <input type="checkbox"/> Debridement And Implant Retention (DAIR) without Modular Exchange <input type="checkbox"/> Application Posterior Lip Augmentation Device (PLAD) <input type="checkbox"/> Modular Exchange for indications other than infection <input type="checkbox"/> Revision Not Classified Elsewhere (e.g. Hybrid) <input type="checkbox"/>	
Patient Position	Lateral <input type="checkbox"/>	Supine <input type="checkbox"/>
Approach	Hardinge/Anterolateral <input type="checkbox"/> Posterior <input type="checkbox"/> Trochanteric Osteotomy <input type="checkbox"/>	Extended Trochanteric Osteotomy <input type="checkbox"/> Direct Anterior <input type="checkbox"/> Other <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 (Not applicable for DAIR procedures, i.e. DAIR <u>with</u> or <u>without</u> modular exchange)					
Was Femoral Bone graft Used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Femoral - Form	Structural <input type="checkbox"/>	Morsellised/chips <input type="checkbox"/>			
Femoral - Type	Autograft <input type="checkbox"/>	Allograft <input type="checkbox"/>	Synthetic <input type="checkbox"/>	Other <input type="checkbox"/>	
Was Acetabular Bone graft Used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Acetabular - Form	Structural <input type="checkbox"/>	Morsellised/chips <input type="checkbox"/>			
Acetabular - 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	None	<input type="checkbox"/>	Shaft Fracture	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Calcar Crack	<input type="checkbox"/>	Shaft Penetration	<input type="checkbox"/>		
	Pelvic Penetration	<input type="checkbox"/>	Trochanteric Fracture	<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, endoprotheses or bipolar heads.

Cup or Shell

Liner (if used)

Stem

Head

Cement (if used)

Accessories (not screws)