



S2

Shoulder Single Stage Revision
Shoulder Stage 1 of 2 Stage Revision
Shoulder Stage 2 of 2 Stage Revision
Conversion to Arthrodesis
Excision Arthroplasty
Amputation
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 <small>(IN M)</small>	Weight <small>(IN KG)</small>	BMI	Not Available <input type="checkbox"/>
Handedness	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Ambidextrous <input type="checkbox"/>	Unknown <input type="checkbox"/>

PATIENT IDENTIFIERS

Forename(s)				
Surname				
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Not Known <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"/>		
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"/>		

SHOULDER REVISION PROCEDURE DETAILS

Procedure Type	Single Stage Revision (includes modular exchange for indications other than infection)	<input type="checkbox"/>	Conversion to Arthrodesis	<input type="checkbox"/>
	Stage 1 of 2 Stage Revision	<input type="checkbox"/>	Excision Arthroplasty	<input type="checkbox"/>
	Stage 2 of 2 Stage Revision	<input type="checkbox"/>	Amputation	<input type="checkbox"/>
			Debridement and Implant Retention (DAIR)	<input type="checkbox"/>
Revision of	Primary 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 (select all that apply)	Infection	<input type="checkbox"/>	Glenoid Implant Wear	<input type="checkbox"/>
	Instability	<input type="checkbox"/>	Native Glenoid Surface Erosion	<input type="checkbox"/>
	Cuff Insufficiency	<input type="checkbox"/>	Implant Fracture	<input type="checkbox"/>
	Aseptic Loosening Humerus	<input type="checkbox"/>	Lysis – Humerus	<input type="checkbox"/>
	Aseptic Loosening Glenoid	<input type="checkbox"/>	Lysis - Glenoid	<input type="checkbox"/>
	Peri-prosthetic Fracture	<input type="checkbox"/>	Dislocation/Subluxation	<input type="checkbox"/>
	Stiffness	<input type="checkbox"/>	Unexplained pain	<input type="checkbox"/>
	Impingement	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Component Dissociation	<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)

Humeral Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Humeral Articulating Bearing Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glenoid Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glenoid Articulating Bearing Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other Component Removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

Patient Procedure (i.e. revision to)	Revision Resurfacing Total Arthroplasty	<input type="checkbox"/>		
	Revision Resurfacing Hemi-arthroplasty	<input type="checkbox"/>		
	Revision Stemless Conventional Total Arthroplasty	<input type="checkbox"/>		
	Revision Stemless Hemi-arthroplasty	<input type="checkbox"/>		
	Revision Stemless Total Reverse Arthroplasty	<input type="checkbox"/>		
	Revision Stemmed Conventional Total Arthroplasty	<input type="checkbox"/>		
	Revision Stemmed Hemi-arthroplasty	<input type="checkbox"/>		
	Revision Stemmed Total Reverse Arthroplasty	<input type="checkbox"/>		
	Revision Glenohumeral Interpositional 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"/>		
	Modular exchange for indications other than infection	<input type="checkbox"/>		
Fixation Humerus (Not applicable for either type of DAIR procedure)	Uncemented <input type="checkbox"/>	Cemented <input type="checkbox"/>	Not applicable <input type="checkbox"/>	
Fixation Glenoid (Not applicable for either type of DAIR procedure)	Uncemented <input type="checkbox"/>	Cemented <input type="checkbox"/>	Not applicable <input type="checkbox"/>	
Approach	Delto-pectoral <input type="checkbox"/>	Trans-deltoid <input type="checkbox"/>	Other <input type="checkbox"/>	
Patient Specific Instruments? (Not applicable for DAIR without modular exchange)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Biological Resurfacing (Glenoid) (select all that apply) (Not applicable for either type of DAIR procedure)	None <input type="checkbox"/>	Reaming <input type="checkbox"/>	Microfracture <input type="checkbox"/>	Interposition <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 with or without modular exchange)

Was Humeral Bone graft used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>					
Humeral – Form	Structural	<input type="checkbox"/>	Morsellised/chips	<input type="checkbox"/>				
Humeral – Type	Autograft	<input type="checkbox"/>	Allograft	<input type="checkbox"/>	Synthetic	<input type="checkbox"/>	Other	<input type="checkbox"/>
Was Glenoid Bone graft used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>					
Glenoid – Form	Structural	<input type="checkbox"/>	Morsellised/chips	<input type="checkbox"/>				
Glenoid - Type	Autograft	<input type="checkbox"/>	Allograft	<input type="checkbox"/>	Synthetic	<input type="checkbox"/>	Other	<input type="checkbox"/>

Rotator Cuff

Rotator Cuff Condition	Normal	<input type="checkbox"/>	Attenuated	<input type="checkbox"/>	Absent/Torn	<input type="checkbox"/>
Rotator Cuff Repaired?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Repair Type	Primary Repair	<input type="checkbox"/>	Augmented Patch Repair	<input type="checkbox"/>		

Other Soft Tissues

Long Head Biceps (LHB) Present?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
LHB Tenotomy Performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
LHB Tenodesis Performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Muscle Transfer?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

SURGEON'S NOTES

INTRA-OPERATIVE EVENT

Untoward Intra-Operative Event	None	<input type="checkbox"/>	Fracture Glenoid	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Fracture Humerus	<input type="checkbox"/>	Vascular Injury	<input type="checkbox"/>		

PRE-OPERATIVE OXFORD SCORES – Tick one box for every question. If no scores available select Pre-operative Oxford Scores Not available

Pre-operative Oxford Score Date	DD/MM/YYYY	Not available	<input type="checkbox"/>
1.	During the past 4 weeks... How would you describe the worst pain you had <u>from your shoulder</u> ?	Not available	<input type="checkbox"/>
	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>
	Severe <input type="checkbox"/>	Unbearable	<input type="checkbox"/>
2.	During the past 4 weeks... Have you had any trouble dressing yourself <u>because of your shoulder</u> ?	Not available	<input type="checkbox"/>
	No trouble at all <input type="checkbox"/>	A little bit of trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>
	Extreme difficulty <input type="checkbox"/>	Impossible to do	<input type="checkbox"/>
3.	During the past 4 weeks... Have you had any trouble getting in and out of a car or using public transport <u>because of your shoulder</u> ?	Not available	<input type="checkbox"/>
	No trouble at all <input type="checkbox"/>	A little bit of trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>
	Extreme difficulty <input type="checkbox"/>	Impossible to do	<input type="checkbox"/>
4.	During the past 4 weeks... Have you been able to use a knife and fork <u>at the same time</u> ?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With extreme difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
5.	During the past 4 weeks... Could you do the household shopping <u>on your own</u> ?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With extreme difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
6.	During the past 4 weeks... Could you carry a tray containing a plate of food across a room?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With extreme difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
7.	During the past 4 weeks... Could you brush/comb your hair <u>with the affected arm</u> ?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With extreme difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
8.	During the past 4 weeks... How would you describe the pain you <u>usually</u> had from your shoulder?	Not available	<input type="checkbox"/>
	None <input type="checkbox"/>	Very mild <input type="checkbox"/>	Mild <input type="checkbox"/>
	Moderate <input type="checkbox"/>	Severe	<input type="checkbox"/>
9.	During the past 4 weeks... Could you hang your clothes up in a wardrobe, <u>using the affected arm</u> ?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With great difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
10.	During the past 4 weeks... Have you been able to wash and dry yourself under both arms?	Not available	<input type="checkbox"/>
	Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
	With extreme difficulty <input type="checkbox"/>	No, impossible	<input type="checkbox"/>
11.	During the past 4 weeks... How much has <u>pain from your shoulder</u> interfered with your usual work (including housework)?	Not available	<input type="checkbox"/>
	Not at all <input type="checkbox"/>	A little bit <input type="checkbox"/>	Moderately <input type="checkbox"/>
	Greatly <input type="checkbox"/>	Totally	<input type="checkbox"/>
12.	During the past 4 weeks... Have you been troubled by <u>pain from your shoulder</u> in bed at night?	Not available	<input type="checkbox"/>
	No nights <input type="checkbox"/>	Only 1 or 2 nights <input type="checkbox"/>	Some nights <input type="checkbox"/>
	Most nights <input type="checkbox"/>	Every night	<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, screws, surgical tools or endoprotheses.

Humeral stem (if used)

Humeral component

Glenoid component (if used)

Cement (if used)

Accessories