



A2

**Ankle Single Stage Revision
Ankle Stage 1 of 2 Stage Revision
Ankle Stage 2 of 2 Stage Revision
Ankle Conversion to Arthrodesis
Amputation**

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"/>
Patient Hospital ID			
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			
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 or National Patient Number (if available)			

OPERATION DETAILS

Hospital			
Operation Date	DD/MM/YYYY		
Anaesthetic Types	General <input type="checkbox"/>	Regional – Nerve Block <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"/> 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 REVISION PROCEDURE DETAILS

Procedure Type	Single Stage Revision <input type="checkbox"/>	Conversion to Arthrodesis <input type="checkbox"/>
	Stage 1 of 2 Stage Revision <input type="checkbox"/>	Amputation <input type="checkbox"/>
	Stage 2 of 2 Stage Revision <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 (select all that apply)	Infection	Implant Fracture
	High Suspicion (eg pus or confined micro) <input type="checkbox"/>	Tibial Component <input type="checkbox"/>
	Low Suspicion (awaiting micro/histo) <input type="checkbox"/>	Talar Component <input type="checkbox"/>
	Aseptic Loosening	Meniscal Component <input type="checkbox"/>
	Tibial Component <input type="checkbox"/>	Wear of Polyethylene Component <input type="checkbox"/>
	Talar Component <input type="checkbox"/>	Meniscal Insert Dislocation <input type="checkbox"/>
	Lysis	Component Migration/Dissociation <input type="checkbox"/>
	Tibia <input type="checkbox"/>	Unexplained Pain <input type="checkbox"/>
	Talus <input type="checkbox"/>	Stiffness <input type="checkbox"/>
	Malalignment <input type="checkbox"/>	Soft Tissue Impingement <input type="checkbox"/>
	Other <input type="checkbox"/>	

PRIMARY OPERATION DETAILS

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

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

Components Removed	Tibial Yes <input type="checkbox"/> No <input type="checkbox"/>	Talar Yes <input type="checkbox"/> No <input type="checkbox"/>	Meniscal Yes <input type="checkbox"/> No <input type="checkbox"/>
Brand	Not Available <input type="checkbox"/>		

SURGICAL APPROACH (Used for Single Stage Revision & Stage 2 of 2 Stage Revision & Conversion to Arthrodesis (Patient Procedure and Surgeon's Notes Only))

Patient Procedure	Prosthetic Replacement Not Using Cement <input type="checkbox"/>	Ankle Fusion (Subtalar joint not fused at this sitting) <input type="checkbox"/>
	Prosthetic Replacement Using Cement <input type="checkbox"/>	Ankle & Subtalar Fusion (using TTC Nail) <input type="checkbox"/>
	Prosthetic Replacement Not Classified <input type="checkbox"/>	Ankle & Subtalar Fusion (not using TTC Nail) <input type="checkbox"/>
	Elsewhere (eg Hybrid) <input type="checkbox"/>	Pantalar Fusion <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"/>	Fibula Osteotomy <input type="checkbox"/>
	Talonavicular Fusion <input type="checkbox"/>	Medial Malleolar Osteotomy <input type="checkbox"/>
	Calcaneal Displacement Osteotomy <input type="checkbox"/>	Lateral Ligament Reconstruction <input type="checkbox"/>
	Achilles Tendon Lengthening <input type="checkbox"/>	Medial Ligament Reconstruction <input type="checkbox"/>
	Fusion Distal Tibiofibular Joint <input type="checkbox"/>	Other <input type="checkbox"/>
		None <input type="checkbox"/>

THROMBOPROPHYLAXIS REGIME (intention to treat)

Chemical (In Hospital)	Aspirin <input type="checkbox"/>	Direct Thrombin Inhibitor <input type="checkbox"/>
	LMWH <input type="checkbox"/>	(e.g. Dabigatran) <input type="checkbox"/>
	Pentasaccharide (e.g. Fondaparinux) <input type="checkbox"/>	Factor Xa Inhibitor <input type="checkbox"/>
	Warfarin <input type="checkbox"/>	(e.g. Rivaroxaban/Apixaban) <input type="checkbox"/>
	Other <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

Was bone graft used?	Yes (structural) <input type="checkbox"/>	Yes (non-structural) <input type="checkbox"/>	No <input type="checkbox"/>
What type of graft was used?	Allograft <input type="checkbox"/>	Autograft <input type="checkbox"/>	Synthetic Graft <input type="checkbox"/>

SURGEON'S NOTES

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INTRA-OPERATIVE EVENT

Untoward Intra-Operative Event (select all that apply)	None	<input type="checkbox"/>	Fracture (other)	<input type="checkbox"/>
	Fracture medial malleolus	<input type="checkbox"/>	Ligament Injury	<input type="checkbox"/>
	Fracture lateral malleolus	<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, endoprotheses or bipolar heads.

Talar Component

Tibial tray component

Meniscal component

Cement (if used)

Accessories