



# H1 Hip 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"/>
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 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"/>
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"/>	4 <input type="checkbox"/>
			5 <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"/>
First Assistant Grade	Consultant <input type="checkbox"/>	Specialty Doctor/SAS <input type="checkbox"/>	Other <input type="checkbox"/>
		Other <input type="checkbox"/>	

## HIP PRIMARY PROCEDURE DETAILS

Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Indications for Implantation (select all that apply)	Osteoarthritis <input type="checkbox"/> Inflammatory Arthropathy <input type="checkbox"/> Congenital Dislocation / Dysplasia of the Hip <input type="checkbox"/> Avascular Necrosis <input type="checkbox"/> Trauma – Acute (Neck of Femur) <input type="checkbox"/> Failed Hemi-Arthroplasty <input type="checkbox"/> Perthes <input type="checkbox"/> Metastatic Cancer/Malignancy <input type="checkbox"/>	Trauma – Chronic <input type="checkbox"/> Previous Hip Surgery – non Trauma related <input type="checkbox"/> Previous Arthrodesis <input type="checkbox"/> Previous Infection <input type="checkbox"/> SUFE <input type="checkbox"/> Skeletal Dysplasia <input type="checkbox"/> Other <input type="checkbox"/>

## SURGICAL APPROACH

Patient Procedure	Primary Total Prosthetic Replacement Using Cement <input type="checkbox"/> Primary Total Prosthetic Replacement Not Using Cement <input type="checkbox"/> Primary Resurfacing Arthroplasty of Joint <input type="checkbox"/> Primary Total Prosthetic Replacement Not Classified Elsewhere (eg Hybrid) <input type="checkbox"/>
Patient Position	Lateral <input type="checkbox"/> Supine <input type="checkbox"/>
Approach	Hardinge <input type="checkbox"/> Trochanteric Osteotomy <input type="checkbox"/> Posterior <input type="checkbox"/> Other <input type="checkbox"/>
Minimally Invasive Technique Used?	Yes <input type="checkbox"/> No <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 <input type="checkbox"/> LMWH <input type="checkbox"/> (eg Dabigatran) Pentasaccharide <input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> (eg Fondaparinux)      (eg Rivaroxaban/Apixaban) Warfarin <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"/>

### BONEGRAFT USED

Femur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Acetabulum	Yes <input type="checkbox"/> No <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"/>
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# 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)