



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

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			
Handedness	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Ambidextrous <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"/>
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	<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"/>
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"/>	Periprosthetic Fracture	<input type="checkbox"/>
	Instability	<input type="checkbox"/>	Conversion Hemi to Total	<input type="checkbox"/>
	Cuff Insufficiency	<input type="checkbox"/>	Conversion Total to Hemi	<input type="checkbox"/>
	Aseptic Loosening	<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)			
Humeral	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Glenoid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Applicable (Revision of Hemi) <input type="checkbox"/>
Brand	Not Available <input type="checkbox"/>		

SURGICAL APPROACH (Used for Single Stage Revision & Stage 2 of 2 Stage Revision)			
Patient Procedure	Revision Total Prosthetic Replacement	<input type="checkbox"/>	
	Revision Hemi-arthroplasty of Joint	<input type="checkbox"/>	
	Revision Resurfacing Arthroplasty of Joint	<input type="checkbox"/>	
	Revision Resurfacing Hemi-arthroplasty of Joint	<input type="checkbox"/>	
	Revision Reverse Polarity Total Prosthetic Replacement	<input type="checkbox"/>	
Fixation Type	Cementless <input type="checkbox"/>	Cemented <input type="checkbox"/>	Hybrid <input type="checkbox"/>
Approach	Delto-Pectoral	<input type="checkbox"/>	Deltoid Detachment <input type="checkbox"/>
	Superior (MacKenzie)	<input type="checkbox"/>	Posterior <input type="checkbox"/>
	Deltoid Split	<input type="checkbox"/>	
Biological Resurfacing (Glenoid) (select all that apply)	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 <input type="checkbox"/>
	LMWH	<input type="checkbox"/>	(eg Dabigatran)
	Pentasaccharide (eg Fondaparinux)	<input type="checkbox"/>	Factor Xa Inhibitor <input type="checkbox"/>
	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"/>	

BONE GRAFT USED			
Humeral Bone Graft	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Glenoid Bone Graft	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

SOFT TISSUES			
Long Head Biceps Tenotomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Rotator Cuff Condition	Normal <input type="checkbox"/>	Attenuated <input type="checkbox"/>	Absent/Torn <input type="checkbox"/> Repaired <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"/>
	Shaft Penetration	<input type="checkbox"/>	Nerve Injury <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 Scores Not available		Not available <input type="checkbox"/>
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