

KAISER PERMANENTE®
ACLR REGISTRY
OPERATIVE FORM
Registry Form

NAME: _____

MRN: _____

SURGEON	DOB	
	/ /	
OPERATIVE DATE (MM/DD/YY)	OPERATIVE SITE	GENDER
/ /	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

- Central Denver
 South Denver
 Rock Creek

INJURY DATE (MM/DD/YY): / / **Occupational Health Services/Workers comp (please check):**

Diagnosis	Reconstructed	Repair	Left in situ	None-Healed at time of surgery	Other	<u>Activities that lead to injury:</u>	
<input type="checkbox"/> ACL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Basketball
<input type="checkbox"/> ALL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cheerleading/Dance	<input type="checkbox"/> Cycle
<input type="checkbox"/> LCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fall	<input type="checkbox"/> Football
<input type="checkbox"/> MCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Martial Arts
<input type="checkbox"/> PCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MCA/MVA	<input type="checkbox"/> Racket Sports
<input type="checkbox"/> PLC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Running/Hiking/Walking	<input type="checkbox"/> Skateboard
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Skiing/Snowboarding	<input type="checkbox"/> Soccer
<input type="checkbox"/> None						<input type="checkbox"/> Volleyball	<input type="checkbox"/> Water Sports
						<input type="checkbox"/> Work	<input type="checkbox"/> Other: _____

Is this a: Revision No Yes Single Stage Stage 1 of 2 Stage 2 of 2

Index knee prior meniscus/ cartilage surgery: No Yes- if yes, what procedure:
 Meniscus repair Meniscus transplant Microfracture/drilling Osteochondral autograft
 Osteochondral allograft Partial or total meniscectomy abrasion Other: _____

Contralateral knee normal: Yes No – if no, please describe:
 Cartilage injury/surgery Current ACL Insufficiency Ligament injury/surgery Meniscus injury/surgery
 Prior ACL reconstruction Other ligament injury/surgery:

Cartilage Injury Location	Size (mm)	Grade	WBA(°)	None	Debridement	Microfx/drilling abrasion	Osteochondral allograft	Osteochondral autograft	Other
<input type="checkbox"/> Patella	_x_		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Trochlea	_x_			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MFC	_x_			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LFC	_x_			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MTP	_x_		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LTP	_x_		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p><input type="checkbox"/> MEDIAL Meniscus</p> <p>Type: <input type="checkbox"/> Complex <input type="checkbox"/> Radial <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Partial Thickness Tear <input type="checkbox"/> Root Tear <input type="checkbox"/> Other: _____</p> <p>Length (mm): _____</p> <p>Procedure (check all that apply):</p> <p><input type="checkbox"/> Repair: <input type="checkbox"/> Sutures <input type="checkbox"/> All inside device <input type="checkbox"/> Sutures through tunnel w/ Button <input type="checkbox"/> Sutures through tunnel w/ Bone Anchor <input type="checkbox"/> Sutures through tunnel w/ Bone Bridge</p> <p><input type="checkbox"/> Partial meniscectomy: _____% remaining <input type="checkbox"/> Trephinated <input type="checkbox"/> Rased <input type="checkbox"/> Left in situ</p>	<p><input type="checkbox"/> LATERAL Meniscus</p> <p>Type: <input type="checkbox"/> Complex <input type="checkbox"/> Radial <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Partial Thickness Tear <input type="checkbox"/> Root Tear <input type="checkbox"/> Other: _____</p> <p>Length (mm): _____</p> <p>Procedure (check all that apply):</p> <p><input type="checkbox"/> Repair: <input type="checkbox"/> Sutures <input type="checkbox"/> All inside device <input type="checkbox"/> Sutures through tunnel w/ Button <input type="checkbox"/> Sutures through tunnel w/ Bone Anchor <input type="checkbox"/> Sutures through tunnel w/ Bone Bridge</p> <p><input type="checkbox"/> Partial meniscectomy _____% remaining <input type="checkbox"/> Trephinated <input type="checkbox"/> Rased <input type="checkbox"/> Left in situ</p>
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Physis: Open Closed **Femoral tunnel drilled via:** Tibial tunnel Medial portal Lateral approach Unknown

SINGLE BUNDLE

AUTOGRAFT										
Graft Type	ACL	ALL	LCL	MCL	PCL	PLC	OTHER____	Width (mm)	Diameter	Number of Strands
BPTB										
HAMSTRING										
QUAD TENDON										
REPAIR ONLY										
OTHER_____										

ALLOGRAFT										
Graft Type	ACL	ALL	LCL	MCL	PCL	PLC	OTHER____	Width (mm)	Diameter	Number of Strands
BPTB										
ACHILLES										
TIBIALIS ANTERIOR										
TIBIALIS POSTERIOR										
QUAD TENDON										
HAMSTRING										
PERONEUS LONGUS										
REPAIR ONLY										
OTHER_____										

DOUBLE BUNDLE

AUTOGRAFT					
Graft Type	Anteromedial-Double Bundle	Posterolateral-Double Bundle	Width (mm)	Diameter	Number of Strands
BPTB					
HAMSTRING					
QUAD TENDON					
OTHER_____					

ALLOGRAFT					
Graft Type	Anteromedial-Double Bundle	Posterolateral-Double Bundle	Width (mm)	Diameter	Number of Strands
BPTB					
ACHILLES					
TIBIALIS ANTERIOR					
TIBIALIS POSTERIOR					
QUAD TENDON					
HAMSTRING					
PERONEUS LONGUS					
OTHER_____					

ACL GRAFT FIXATION (please place implant labels in appropriate section below):

Femoral

None (please check)

Tibial

None (please check)

SUPPLEMENTAL FIXATION:

Femoral

None (please check)

Tibial

None (please check)

ADDITIONAL FIXATION IMPLANTS: **None** (please check)

MENISCAL FIXATION IMPLANTS: **None** (please check)

GRAFT: **None** (please check)

OTHER GENERAL IMPLANTS: **None** (please check)