

**KAISER PERMANENTE®**  
**ACLR REGISTRY**  
**OPERATIVE FORM**  
**Registry Form**

NAME: \_\_\_\_\_

KAISER MRN: \_\_\_\_\_

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

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	<b>Activities that lead to injury:</b>
<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"/> Cheerleading/Dance <input type="checkbox"/> Cycle <input type="checkbox"/> Fall <input type="checkbox"/> Football <input type="checkbox"/> Gymnastics <input type="checkbox"/> Martial Arts <input type="checkbox"/> MCA/MVA <input type="checkbox"/> Racket Sports <input type="checkbox"/> Running/Hiking/Walking <input type="checkbox"/> Skateboard <input type="checkbox"/> Skiing/Snowboarding <input type="checkbox"/> Soccer <input type="checkbox"/> Volleyball <input type="checkbox"/> Water Sports <input type="checkbox"/> Work <input type="checkbox"/> Other: _____
<input type="checkbox"/> ALL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> LCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> MCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> PCL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> PLC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> None						

**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"/> <b>MEDIAL Meniscus</b></p> <p><b>Type:</b>                      <b>Length (mm):</b></p> <p> <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><b>Procedure (check all that apply):</b></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  <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"/> <b>LATERAL Meniscus</b></p> <p><b>Type:</b>                      <b>Length (mm):</b></p> <p> <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><b>Procedure (check all that apply):</b></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  <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**

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

<b>ALLOGRAFT</b>										
<b>Graft Type</b>	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**

<b>AUTOGRAFT</b>					
<b>Graft Type</b>	Anteromedial-Double Bundle	Posterolateral-Double Bundle	Width (mm)	Diameter	Number of Strands
BPTB					
HAMSTRING					
QUAD TENDON					
OTHER____					

<b>ALLOGRAFT</b>					
<b>Graft Type</b>	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)