TOTAL HIP ARTHROPLASTY OPERATIVE FORM

Registry Form

Name: ______________________________

MRN: ______________________________

Imprint Area

CIRCULATING NURSE PLEASE COMPLETE

KAISER MRN:

SURGEON	DOB (MM/DD/YY)
OPERATIVE DATE (MM/DD/YY) / /	GENDER ☐ MALE ☐ FEMALE

PLEASE CHECK YOUR LOCATION:
☐CDV
☐RCK
☐SDV
☐CO_OTHER

Operative Side: ☐Left ☐Right **Same day bilateral procedure?** ☐No ☐Yes

Anesthesia: (Mark all that apply) ☐General ☐Spinal ☐Epidural ☐Regional ☐Femoral Nerve Block ☐MAC ☐Other________

ASA Score: ☐1 ☐2 ☐3 ☐4 ☐5

Infection Prophylaxis: ☐Antibiotics Irrigation ☐Antibiotics in Cement ☐IV Antibiotics ☐Laminar Flow ☐Space Suits ☐Other: ____________________

Operative time: (skin-to-skin) __________ mins **EBL:** __________ ml

Drain: ☐Reinfusion ☐Non-Reinfusion ☐None

Reason for Surgery *(Check all that apply)*

☐**Osteoarthritis (OA)**
☐**Rheumatoid arthritis (RA)**
☐**Inflammatory arthritis (Non-RA)**
☐**Post traumatic arthritis**
☐Aseptic loosening
☐Component fracture
☐Cup malposition
☐Dysplasia
☐Failed hemiarthroplasty
☐Failed ORIF
☐Heterotopic Ossification
☐Infection
☐Instability
☐Liner wear
☐LLD (Leg Length Discrepancy)
☐Metallosis
☐Osteolysis
☐Osteonecrosis/Avascular necrosis
☐Pain
☐Peri-prosthetic fracture of ____________________
☐Seroma/Hematoma
☐Wound dehiscence
☐Wound drainage
☐Other________________ ________________

Revision: ☐Yes ☐No **Conversion:** ☐Yes ☐No

Procedure *(Check all that apply)*

☐**Total hip arthroplasty**
☐**THA revision**
☐**Hemi converted to THA**
☐**ORIF changed to THA**
☐CAS (Computer Assisted Surgery)
☐Femoral head replacement
☐Hemi revised to Hemi
☐HWR (Hardware removal)
☐I & D
☐Liner exchange
☐ORIF changed to Hemi
☐ORIF of__________________
☐Revision acetabulum
☐Revision femur
☐Stage 1 - explantation
☐Stage 2 – reimplantation
☐Total hip resurfacing / BHR
☐Other__________________

Cement: ☐None ☐All ☐Acetabulum ☐Femur

Cement as Filler: ☐None ☐Structural ☐Non-Structural ☐Rebar ☐Other: ______________________________

Bone graft: ☐None ☐Non-Structural ☐Structural ***(Specify location):*** ☐Acetabulum ☐Femur

Protrusio acetabulae: ☐Yes ☐No

Surgical Approach: ☐Anterior ☐Direct lateral ☐Posterior ☐Other______________________ ☐Anterolateral ☐Mini ☐Trochanteric osteotomy

Intra-op Complications? ☐Yes ☐No **If *yes,* specify**______________________________

VTE Prophylaxis:*(list all anticipated)*

☐**Coumadin**
☐**Low molecular weight heparin**
☐Arixtra(fondaparinux)
☐Aspirin
☐Foot pump
☐SCD
☐TED hose
☐Xarelto(rivaroxaban)
☐Other________________

SIGNATURES:	DATE:

Please scan & email to 18445270153@fax.kp.org; or secure efax to 844-527-0153.

PLACE IMPLANT STICKERS HERE

Stem	Femoral Head
Cup	**Cup Insert**
Cement	**Screws**
Post	**Cables**