



**TOTAL HIP ARTHROPLASTY
OPERATIVE FORM
Registry Form**

Name: _____

MRN: _____

Imprint Area

SURGEON		DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION: <input type="checkbox"/> DCSM <input type="checkbox"/> GBMC <input type="checkbox"/> NOVA <input type="checkbox"/> MAS_OTHER
OPERATIVE DATE (MM/DD/YY) ____/____/____		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

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)

- | | | | |
|----------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Osteoarthritis (OA) | <input type="checkbox"/> Dysplasia | <input type="checkbox"/> LLD (Leg Length Discrepancy) | <input type="checkbox"/> Wound dehiscence |
| <input type="checkbox"/> Rheumatoid arthritis (RA) | <input type="checkbox"/> Failed hemiarthroplasty | <input type="checkbox"/> Metallosis | <input type="checkbox"/> Wound drainage |
| <input type="checkbox"/> Inflammatory arthritis (Non-RA) | <input type="checkbox"/> Failed ORIF | <input type="checkbox"/> Osteolysis | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Post traumatic arthritis | <input type="checkbox"/> Heterotopic Ossification | <input type="checkbox"/> Osteonecrosis/Avascular necrosis | _____ |
| <input type="checkbox"/> Aseptic loosening | <input type="checkbox"/> Infection | <input type="checkbox"/> Pain | |
| <input type="checkbox"/> Component fracture | <input type="checkbox"/> Instability | <input type="checkbox"/> Peri-prosthetic fracture of _____ | |
| <input type="checkbox"/> Cup malposition | <input type="checkbox"/> Liner wear | <input type="checkbox"/> Seroma/Hematoma | |

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

Procedure (Check all that apply)

- | | | |
|----------------------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Total hip arthroplasty | <input type="checkbox"/> Hemi revised to Hemi | <input type="checkbox"/> Revision acetabulum |
| <input type="checkbox"/> THA revision | <input type="checkbox"/> HWR (Hardware removal) | <input type="checkbox"/> Revision femur |
| <input type="checkbox"/> Hemi converted to THA | <input type="checkbox"/> I & D | <input type="checkbox"/> Stage 1 - explantation |
| <input type="checkbox"/> ORIF changed to THA | <input type="checkbox"/> Liner exchange | <input type="checkbox"/> Stage 2 - reimplantation |
| <input type="checkbox"/> CAS (Computer Assisted Surgery) | <input type="checkbox"/> ORIF changed to Hemi | <input type="checkbox"/> Total hip resurfacing / BHR |
| <input type="checkbox"/> Femoral head replacement | <input type="checkbox"/> ORIF of _____ | <input type="checkbox"/> 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)

- | | | | | |
|-------------------------------------------------------|------------------------------------------------|------------------------------------|-----------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Arixtra(fondaparinux) | <input type="checkbox"/> Foot pump | <input type="checkbox"/> TED hose | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Low molecular weight heparin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> SCD | <input type="checkbox"/> Xarelto(rivaroxaban) | |

SIGNATURES: _____ DATE: _____

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

PLACE IMPLANT STICKERS HERE

<p>Stem</p>	<p>Femoral Head</p>
<p>Cup</p>	<p>Cup Insert</p>
<p>Cement</p>	<p>Screws</p>
<p>Post</p>	<p>Cables</p>