KAISER PERMANENTE®

TOTAL HIP ARTHROPLASTY OPERATIVE FORM
Registry Form

Name: _____

MRN: _____

Imprint Area

SURGEON	DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION: ☐KSMC ☐KWMC ☐NW_OTHER
OPERATIVE DATE (MM/DD/YY) / /	GENDER ☐ MALE ☐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)*

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

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

Procedure *(Check all that apply)*

☐**Total hip arthroplasty**	☐Hemi revised to Hemi	☐Revision acetabulum
☐**THA revision**	☐HWR (Hardware removal)	☐Revision femur
☐**Hemi converted to THA**	☐I & D	☐Stage 1 - explantation
☐**ORIF changed to THA**	☐Liner exchange	☐Stage 2 – reimplantation
☐CAS (Computer Assisted Surgery)	☐ORIF changed to Hemi	☐Total hip resurfacing / BHR
☐Femoral head replacement	☐ORIF of_____	☐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**	☐Arixtra(fondaparinux)	☐Foot pump	☐TED hose	☐Other_____
☐**Low molecular weight heparin**	☐Aspirin	☐SCD	☐Xarelto(rivaroxaban)	

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**