



**TOTAL HIP ARTHROPLASTY
OPERATIVE FORM
Registry Form**

Name: _____

MRN: _____

Imprint Area

SURGEON	DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION:		
		<input type="checkbox"/> AVH	<input type="checkbox"/> KC	<input type="checkbox"/> RIV
		<input type="checkbox"/> BP	<input type="checkbox"/> LA	<input type="checkbox"/> SB
OPERATIVE DATE (MM/DD/YY)	GENDER	<input type="checkbox"/> COA	<input type="checkbox"/> MVH	<input type="checkbox"/> SD
/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> DOW	<input type="checkbox"/> OC	<input type="checkbox"/> WH
		<input type="checkbox"/> SBC	<input type="checkbox"/> PC	<input type="checkbox"/> WLA

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>