



**TOTAL HIP ARTHROPLASTY  
OPERATIVE FORM  
Registry Form**

Name: \_\_\_\_\_

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

Imprint Area

CIRCULATING NURSE PLEASE COMPLETE

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

|                                  |  |  |
|----------------------------------|--|--|
| SURGEON                          | DOB (MM/DD/YY)   | PLEASE CHECK YOUR LOCATION:<br><input type="checkbox"/> CDV<br><input type="checkbox"/> RCK<br><input type="checkbox"/> SDV<br><input type="checkbox"/> CO_OTHER |
| OPERATIVE DATE (MM/DD/YY)<br>/ / | GENDER:<br><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"/> Seroma/Hematoma  |
| <input type="checkbox"/> Rheumatoid arthritis (RA)       | <input type="checkbox"/> Failed hemiarthroplasty  | <input type="checkbox"/> Metallosis                        | <input type="checkbox"/> Wound dehiscence |
| <input type="checkbox"/> Inflammatory arthritis (Non-RA) | <input type="checkbox"/> Failed ORIF              | <input type="checkbox"/> Osteolysis                        | <input type="checkbox"/> Wound drainage   |
| <input type="checkbox"/> Post traumatic arthritis        | <input type="checkbox"/> Heterotopic Ossification | <input type="checkbox"/> Osteonecrosis/Avascular necrosis  | <input type="checkbox"/> Other _____      |
| <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               |  |   |

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

**Procedure (Check all that apply)**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Total hip arthroplasty | <input type="checkbox"/> HWR (Hardware removal)   | <input type="checkbox"/> Revision acetabulum             | <input type="checkbox"/> RAS (Robotic Assisted Surgery) |
| <input type="checkbox"/> THA revision           | <input type="checkbox"/> I&D                      | <input type="checkbox"/> Revision femur                  | <input type="checkbox"/> Zimmer-ROSA                    |
| <input type="checkbox"/> Hemi converted to THA  | <input type="checkbox"/> Liner exchange           | <input type="checkbox"/> Stage 1 – explantation          | <input type="checkbox"/> SmithNephew-CORI               |
| <input type="checkbox"/> Hemi revised to Hemi   | <input type="checkbox"/> Femoral head replacement | <input type="checkbox"/> Stage 2 – reimplantation        | <input type="checkbox"/> Depuy-VELYS                    |
| <input type="checkbox"/> ORIF changed to THA    | <input type="checkbox"/> Other: _____             | <input type="checkbox"/> Total hip resurfacing / BHR     | <input type="checkbox"/> Stryker-MAKO                   |
| <input type="checkbox"/> ORIF changed to Hemi   |   | <input type="checkbox"/> CAS (Computer Assisted Surgery) | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> ORIF of _____          |   |  | <input type="checkbox"/> RAS Version: _____             |

**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 [implantregistries-forms@kp.org](mailto:implantregistries-forms@kp.org); or secure efax to 844-527-0153.

*PLACE IMPLANT STICKERS HERE*

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