



**TOTAL KNEE ARTHROPLASTY
OPERATIVE FORM
Registry Form**

Name: _____

MRN: _____

Imprint Area

CIRCULATING NURSE PLEASE COMPLETE

KAISER MRN:

SURGEON	DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION: <input type="checkbox"/> CDV <input type="checkbox"/> RCK <input type="checkbox"/> SDV <input type="checkbox"/> CO_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 *If yes,* Sequential (1 surgeon) Simultaneous (2 surgeons)

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

Tourniquet Time: _____ mins **Pressure:** _____ mmHg

Drain: Reinfusion Non-Reinfusion None

Reason for surgery (Check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Osteoarthritis (OA) | <input type="checkbox"/> Failed Ext. Mech. | <input type="checkbox"/> Ingrowth failure | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Rheumatoid arthritis (RA) | <input type="checkbox"/> Failed HTO | <input type="checkbox"/> Instability | <input type="checkbox"/> Seroma/Hematoma |
| <input type="checkbox"/> Inflammatory arthritis (Non-RA) | <input type="checkbox"/> Failed ORIF | <input type="checkbox"/> Liner wear | <input type="checkbox"/> Synovial impingement |
| <input type="checkbox"/> Post traumatic arthritis | <input type="checkbox"/> Failed UKA | <input type="checkbox"/> Osteolysis | <input type="checkbox"/> Wound dehiscence |
| <input type="checkbox"/> Arthrofibrosis | <input type="checkbox"/> Failed Uni-spacer | <input type="checkbox"/> Osteonecrosis/Avascular necrosis | <input type="checkbox"/> Wound drainage |
| <input type="checkbox"/> Aseptic loosening | <input type="checkbox"/> Femoral fracture | <input type="checkbox"/> Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Component fracture | <input type="checkbox"/> Tibial fracture | <input type="checkbox"/> PF joint malfunction | |

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

Procedure (Check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> TKA with patella | <input type="checkbox"/> HWR | <input type="checkbox"/> Revision femur | <input type="checkbox"/> RAS (Robotic Assisted Surgery) |
| <input type="checkbox"/> TKA without patella | <input type="checkbox"/> I&D | <input type="checkbox"/> Revision patella | <input type="checkbox"/> Zimmer-ROSA |
| <input type="checkbox"/> TKA revision | <input type="checkbox"/> Liner exchange | <input type="checkbox"/> Revision tibia | <input type="checkbox"/> SmithNephew-CORI |
| <input type="checkbox"/> TKA revision | <input type="checkbox"/> MUA | <input type="checkbox"/> Stage 1 – explantation | <input type="checkbox"/> Depuy-VELYS |
| <input type="checkbox"/> UKA (medial) | <input type="checkbox"/> ORIF changed to TKA | <input type="checkbox"/> Stage 2 – reimplantation | <input type="checkbox"/> Stryker-MAKO |
| <input type="checkbox"/> UKA (lateral) | <input type="checkbox"/> ORIF of _____ | <input type="checkbox"/> Synovectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> UKA converted to TKA | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> CAS (Computer Assisted Surgery) | <input type="checkbox"/> RAS Version: _____ |
| <input type="checkbox"/> Patellofemoral uni/arthroplasty | | | |

Cement: None All Patella Tibia Femur

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

Soft Tissue Releases: Lateral retinaculum (patellar tracking) Yes No

Exposure: Mid-vastus Parapatellar Sub-vastus Tubercle osteotomy
 Mini Quadriceps release Trivector Other _____

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; or secure efax to 844-527-0153.

PLACE IMPLANT STICKERS HERE

<p>Femoral Component</p>	<p>Tibial Tray</p>
<p>Tibial Insert</p>	<p>Patella</p>
<p>Cement</p>	<p>Screws</p>