



**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:		
		<input type="checkbox"/> AVH	<input checked="" 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"/> 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; 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>