KAISER PERMANENTE®

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:
		☐BVU (Bellevue / Overlake) ☐CAP (Capitol Hill) ☐TSC (Tacoma / St. Joseph) ☐SWE (Swedish Medical Center)
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)	☐Seroma/Hematoma
☐**Rheumatoid arthritis (RA)**	☐Failed hemiarthroplasty	☐Metallosis	☐Wound dehiscence
☐**Inflammatory arthritis (Non-RA)**	☐Failed ORIF	☐Osteolysis	☐Wound drainage
☐**Post traumatic arthritis**	☐Heterotopic Ossification	☐Osteonecrosis/Avascular necrosis	☐Other _____
☐Aseptic loosening	☐Infection	☐Pain	
☐Component fracture	☐Instability	☐Peri-prosthetic fracture of _____	
☐Cup malposition	☐Liner wear		

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

Procedure *(Check all that apply)*

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

☐**Coumadin**	☐Arixtra(fondaparinux)	☐Foot pump	☐TED hose	☐Other_____
☐**Low molecular weight heparin**	☐Aspirin	☐SCD	☐Xarelto(rivaroxaban)	

SIGNATURES: DATE:

Please scan & email to implantregistries-forms@kp.org; or secure efax to 844-527-0153.

PLACE IMPLANT STICKERS HERE

Stem	**Femoral Head**
Cup	**Cup Insert**
Cement	**Screws**
Post	**Cables**