KAISER PERMANENTE®

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:
OPERATIVE DATE (MM/DD/YY) / /	GENDER: ☐MALE ☐FEMALE	☐BVU (Bellevue / Overlake) ☐CAP (Capitol Hill) ☐TSC (Tacoma / St. Joseph) ☐SWE (Swedish Medical Center)

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)*

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

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

Procedure ***(Check all that apply)***

☐**TKA with patella**	☐HWR	☐Revision femur	☐RAS (Robotic Assisted Surgery)
☐**TKA without patella**	☐I&D	☐Revision patella	☐Zimmer-ROSA
☐**TKA revision**	☐Liner exchange	☐Revision tibia	☐SmithNephew-CORI
☐**TKA revision**	☐MUA	☐Stage 1 – explantation	☐Depuy-VELYS
☐**UKA (medial)**	☐ORIF changed to TKA	☐Stage 2 – reimplantation	☐Stryker-MAKO
☐**UKA (lateral)**	☐ORIF of _____	☐Synovectomy	☐Other _____
☐UKA converted to TKA	☐Other: _____	☐CAS (Computer Assisted Surgery)	☐RAS Version: _____
☐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)*

☐**Coumadin** ☐Arixtra(fondaparanux) ☐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

Femoral Component	Tibial Tray
Tibial Insert	**Patella**
Cement	**Screws**