

SAOR Primary Hip Arthroplasty

Hospital, Surgeon and Funders												
Hospital of Treatment												
Specialist in Charge												
Performing Clinician	<input type="checkbox"/>	Lead Specialist	<input type="checkbox"/>	Other Specialist	<input type="checkbox"/>	Fellow/Registrar/Resident/Trainee						
Funders	<input type="checkbox"/>	State	<input type="checkbox"/>	Privately Insured	<input type="checkbox"/>	Self-Pay	<input type="checkbox"/>	Foreign Insured				
Patient Details												
Body Mass Index	Height (cm):		Or BMI		<input type="checkbox"/> Not available							
	Weight (kg):											
Patient's Ethnicity	<input type="checkbox"/>	Asian/Chinese	<input type="checkbox"/>	Black	<input type="checkbox"/>	Coloured	<input type="checkbox"/>	Indian	<input type="checkbox"/>	White Caucasian	<input type="checkbox"/>	Other
Anaesthetic Details												
Anaesthetic	<input type="checkbox"/>	General		<input type="checkbox"/>	Sedation		<input type="checkbox"/>	Spinal				
	<input type="checkbox"/>	Epidural		<input type="checkbox"/>	Continuous Epidural Infusion		<input type="checkbox"/>	Regional Block				
	<input type="checkbox"/>	Local Infusion		<input type="checkbox"/>	Other							
Antibiotic	<input type="checkbox"/>	None		<input type="checkbox"/>	Cephalosporin							
	<input type="checkbox"/>	Gentamycin		<input type="checkbox"/>	Other							
Pathology Details												
Indications for Surgery	<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>	Inflammatory Arthritis		<input type="checkbox"/>	Osteonecrosis				
	<input type="checkbox"/>	Dysplasia		<input type="checkbox"/>	Fracture		<input type="checkbox"/>	Tumour				
	<input type="checkbox"/>	Sepsis		<input type="checkbox"/>	Other							
Surgery (Two forms if bilateral)												
Hip Side	<input type="checkbox"/>	Left		<input type="checkbox"/>	Right							
Position	<input type="checkbox"/>	Supine		<input type="checkbox"/>	Lateral Decubitus							
Approach	<input type="checkbox"/>	Posterior		<input type="checkbox"/>	Lateral		<input type="checkbox"/>	Anterior				
	<input type="checkbox"/>	Other										
Bone Graft												
None	<input type="checkbox"/>	Acetabulum		<input type="checkbox"/>	Femoral							
Synthetic Bone Graft Used?	<input type="checkbox"/>	No		<input type="checkbox"/>	Yes							
Surgical Complications												
No Adverse Event	<input type="checkbox"/>	Calcar Crack		<input type="checkbox"/>	Shaft Penetration		<input type="checkbox"/>	Pelvic/Acetabular Penetration				
	<input type="checkbox"/>	Trochanteric Fracture		<input type="checkbox"/>	Other							
Procedure Hip Arthroplasty												
THR	<input type="checkbox"/>	Cemented THR		<input type="checkbox"/>	Uncemented THR							
Hybrid THR	<input type="checkbox"/>	Hybrid THR – Cemented Cup		<input type="checkbox"/>	Hybrid THR – Cemented Stem							
Conversion of Hemi to Primary THR	<input type="checkbox"/>	Cemented Acetabular Cup		<input type="checkbox"/>	Uncemented Acetabular Cup							
	<input type="checkbox"/>	Retaining Stem	<input type="checkbox"/>	Cemented Femoral Stem	<input type="checkbox"/>	Uncemented Femoral Stem						
Resurfacing	<input type="checkbox"/>	Femoral Component Cemented		<input type="checkbox"/>	Femoral Component Uncemented							
Procedure Hemi Arthroplasty												
Hemi	<input type="checkbox"/>	Mono-Component		<input type="checkbox"/>	Bipolar Component							
Component Details												
Acetabular Fixation	<input type="checkbox"/>	N/A		<input type="checkbox"/>	No Screws		<input type="checkbox"/>	Screws Used				
Acetabular insertion	<input type="checkbox"/>	Cement All Poly		<input type="checkbox"/>	Cement Dual Mobility		<input type="checkbox"/>	Uncemented Shell with liner		<input type="checkbox"/>	Uncemented Shell + Cemented Insert	
Femoral Component	<input type="checkbox"/>	Monoblock		<input type="checkbox"/>	Modular Stem		<input type="checkbox"/>	Modular head		<input type="checkbox"/>	Modular neck	
Acetabular Bearing	<input type="checkbox"/>	Poly		<input type="checkbox"/>	Ceramic		<input type="checkbox"/>	Metal		<input type="checkbox"/>	Ceramised Metal	
Femoral Head: Bearing	<input type="checkbox"/>	Metal		<input type="checkbox"/>	Ceramic		<input type="checkbox"/>	Ceramised Metal		<input type="checkbox"/>	Other	
Other Reattachment												
N/A	<input type="checkbox"/>	Cables		<input type="checkbox"/>	Wires		<input type="checkbox"/>	Trochanteric clamp		<input type="checkbox"/>	Other	

Surname	First Name
ID Number	
[PATIENTS STICKER]	
Date of Birth	/ /
Gender	M / F

Email Address
Telephone no.

PLACE PROSTHESIS STICKERS HERE

Component 1	Component 2
Component 3	Component 4

Cement	Synthetic Bone Graft

Additional Implant – Others

Please note this paper is for reference only to enable your secretary or an admin person to transcribe the MDS into the SAOA Registry. Not to be posted or emailed anywhere! (Please ensure that you answer all relevant questions or your submission will not be successful)