

Revision Knee 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):			Weight (kg):			BMI: <input type="checkbox"/> Not available
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"/> GA		<input type="checkbox"/> Sedation		<input type="checkbox"/> Spinal		
	<input type="checkbox"/> Epidural		<input type="checkbox"/> Regional Block		<input type="checkbox"/> Other		
Antibiotic	<input type="checkbox"/> None	<input type="checkbox"/> Cephalosporin		<input type="checkbox"/> Gentamycin	<input type="checkbox"/> Other <small>Free Text Other</small>		

Pathology Details: Indications for Revision Arthroplasty							
<input type="checkbox"/> Aseptic Loosening - Femur	<input type="checkbox"/> Lysis - Femur	<input type="checkbox"/> Peri-prosthetic Fracture - Femur		<input type="checkbox"/> Prosthesis Mismatch			
<input type="checkbox"/> Aseptic Loosening - Tibia	<input type="checkbox"/> Lysis - Tibia	<input type="checkbox"/> Peri-prosthetic Fracture - Tibia		<input type="checkbox"/> Wear of Insert			
<input type="checkbox"/> Infection	<input type="checkbox"/> Instability		<input type="checkbox"/> Pain				
<input type="checkbox"/> Adverse Soft Tissue Reaction to Particulate Debris			<input type="checkbox"/> Other <small>Please free text other</small>				

Surgery (Two forms if bilateral)								
Side	<input type="checkbox"/> Right			<input type="checkbox"/> Left				
Procedure Being Performed	<input type="checkbox"/> Single Stage Revision		<input type="checkbox"/> Stage 1 of 2 Stage		<input type="checkbox"/> Stage 2 of 2 Stage			
	<input type="checkbox"/> Convert to Arthrodesis		<input type="checkbox"/> Amputation		<input type="checkbox"/> Debridement and Implant Retention			
Revision of	<input type="checkbox"/> Primary TKR	<input type="checkbox"/> Uni- Replacement		<input type="checkbox"/> PFJ Replacement		<input type="checkbox"/> Previous Revision TKR		
Revision to	<input type="checkbox"/> Total Revision TKR		<input type="checkbox"/> Total Revision + Distal Fem. EPR		<input type="checkbox"/> Total Revision + Proximal Tib. EPR			
	<input type="checkbox"/> Femoral Revision Only		<input type="checkbox"/> Femoral Revision + Meniscal Exchange		<input type="checkbox"/> Uni- Replacement			
	<input type="checkbox"/> Tibial Revision Only		<input type="checkbox"/> Meniscal Exchange Only		<input type="checkbox"/> PFJ Replacement			
	<input type="checkbox"/> 2° Patella Resurfacing		<input type="checkbox"/> Modular Exchange Indications other than Infection					
	<input type="checkbox"/> Partial Replacement 2 nd Compartment (Uni)			<input type="checkbox"/> Partial Replacement 2 nd Compartment (PFJ)				
Procedure Details								
Tourniquet	<input type="checkbox"/> No Tourniquet		<input type="checkbox"/> Sterile Elastic Tourniquet		<input type="checkbox"/> Pneumatic Tourniquet			
Approach	<input type="checkbox"/> Medial	<input type="checkbox"/> Lateral	<input type="checkbox"/> Sub-vastus		<input type="checkbox"/> Mid-Vastus	<input type="checkbox"/> Other <small>Free Text Other</small>		
More Detail	<input type="checkbox"/> Soft Tissue Release			<input type="checkbox"/> Computer Assisted/Guided Surgery (CAS)				
	<input type="checkbox"/> Patient Specific Instruments (PSI)			<input type="checkbox"/> Customised Prosthesis				

Management of Existing Implants							
	N/A	Left in-situ	Removed	Replaced Cemented	Replaced Uncemented	Inserted 1 st Time Cemented	Inserted 1 st Time Uncemented
Femur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tibial Tray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patella Button	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meniscal Insert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Exchanged		<input type="checkbox"/> New implant Inserted	
Implant Detail							
Meniscal Component	<input type="checkbox"/> Fixed Bearing			<input type="checkbox"/> Mobile Bearing			
Implant Stability	<input type="checkbox"/> Congruent			<input type="checkbox"/> Posterior Stabilised		<input type="checkbox"/> Varus/Valgus Constraint	
Hinged	<input type="checkbox"/> Not Hinged			<input type="checkbox"/> Rotating Hinge		<input type="checkbox"/> Fixed Hinge	
Metal Augments							
Femoral Augments	<input type="checkbox"/>	None		<input type="checkbox"/> Cone	<input type="checkbox"/> Sleeve	<input type="checkbox"/> Stem	
Tibia Augments	<input type="checkbox"/>	None		<input type="checkbox"/> Cone	<input type="checkbox"/> Sleeve	<input type="checkbox"/> Stem	
Other Femoral Augment	<input type="checkbox"/>				<input type="checkbox"/> Other Tibia Augment		
Bone Graft							
Bone Graft Performed	<input type="checkbox"/> Femur			<input type="checkbox"/> Tibia		<input type="checkbox"/> Patella	
Synthetic Bone Graft	<input type="checkbox"/> Femur			<input type="checkbox"/> Tibia		<input type="checkbox"/> Patella	

Surgical Complications/Ligament Damage							
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Adverse Intra-operative Event	<input type="checkbox"/>	No Adverse Event	<input type="checkbox"/>	MCL	<input type="checkbox"/>	LCL
	<input type="checkbox"/>	Quadriceps Tendon	<input type="checkbox"/>	Infrapatellar Tendon	<input type="checkbox"/>	Other <small>Free Text Other</small>

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

Email Address _____
Cell no: _____

PLACE PROSTHESIS STICKERS HERE

Component 1	Component 2
Component 3	Component 4
Cement	Synthetic Bone Graft
Additional Implants - 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. This form is not to be posted or emailed anywhere! (Please ensure that you answer all relevant questions or your submission will not be successful)