KNEE FORM

Australian Orthopaedic Association
National Joint Replacement Registry

SIDE 1

Place **PATIENT DETAILS** label here
and/or
if any patient details are not available on the hospital label please complete below

Surname: ..... Female: ☐ Male: ☐

First Name: ..... Middle Initial: .....

Address: .....

..... Post Code: .....

Hospital Patient No: ..... DOB: ...../...../.....

Medicare No: ..... DVA No. .....
(If applicable)

Name of Hospital: ..... State: .....

Consultant Surgeon Code: .....

Weight (kg) ..... Height (cm) ..... ASA .....

PLEASE COMPLETE THIS SECTION IN FULL

(IF BILATERAL USE **TWO** FORMS)

OPERATION DATE ...../...../..... **L** ☐ **R** ☐

PRIMARY KNEE ☐

includes primary partial or total knee replacement

UNICOMPARTMENTAL Indicate Medial ☐ Lateral ☐

DIAGNOSIS

Osteoarthritis ..... ☐

Rheumatoid Arthritis ..... ☐

Other Inflammatory Arthritis ..... ☐

Osteonecrosis/Avascular Necrosis ..... ☐

Tumour *specify* ..... ☐

.....

Other *specify* ..... ☐

.....

REVISION KNEE ☐

includes removal, exchange or addition of one or more components

UNICOMPARTMENTAL Indicate Medial ☐ Lateral ☐

DIAGNOSIS (Tick more than one box if applicable)

Loosening ..... ☐

Lysis ..... ☐

Infection..... ☐

Implant Breakage *specify* Femoral ☐ Tibial ☐ Patella ☐

Fracture *specify* ..... ☐

Other *specify* ..... ☐

FEMORAL COMPONENTS

(Mark relevant box, place company labels on coloured areas or complete details by hand)

NONE ☐ FEMORAL ☐ STEM ☐

Company .....

Prosthesis Name .....

Cat/Ref No. .....

Lot No. .....

Company .....

Prosthesis Name .....

Cat/Ref No. .....

Lot No. .....

FEMORAL CEMENT **NO** ☐ **YES** ☐

See over for tibial or patella cement

CEMENT NAME: .....

(Use company label or complete details: if more than one mix is used, use only 1 label)

FEMORAL SPACERS

(Complete details by marking boxes)

NONE ☐

DISTAL FEMORAL Medial ☐ Lateral ☐

POSTERIOR CONDYLE Medial ☐ Lateral ☐

Please return form to **Locked Bag 2, Hutt St Post Office, ADELAIDE SA 5000**

Please complete Side 2

TIBIAL COMPONENTS

(Mark relevant box, place company labels on coloured areas or complete details by hand)

NONE ☐ ALL-IN-ONE ☐ BASE PLATE ☐ INSERT ☐ STEM ☐

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

TIBIAL CEMENT **NO** ☐ **YES** ☐

CEMENT NAME: .....

(Use company label or complete details: if more than one mix is used, use only 1 label)

TIBIAL SPACERS

(Complete details by marking boxes)

NONE ☐	**BLOCKS**	Medial ☐	Lateral ☐
	WEDGES	Medial ☐	Lateral ☐
SCREWS	**NO** ☐	**YES** ☐	Number .....

PATELLA COMPONENT

(Mark relevant box, place company labels on coloured areas or complete details by hand)

NONE ☐ **YES** ☐

Company .....
Prosthesis Name .....
Cat/Ref No. .....
Lot No. .....

PATELLA CEMENT **NO** ☐ **YES** ☐

CEMENT NAME: .....

(Use company label or complete details: if more than one mix is used, use only 1 label)

TECHNOLOGY ASSISTED *tick all that apply*

Computer Navigated ..... **NO** ☐ **YES** ☐
System used: .....
Image Derived Instrumentation (IDI)..... **NO** ☐ **YES** ☐
System used: .....
Robotic Assisted ..... **NO** ☐ **YES** ☐
System used: .....
Pressure Sensor ..... **NO** ☐ **YES** ☐
System used: .....
Other ..... **NO** ☐ **YES** ☐
System used: .....

Affix label here if available:

ADDITIONAL COMMENTS (or Extra Labels)

.....

ALL SECTIONS of this form MUST be COMPLETED