KAISER PERMANENTE®

TOTAL HIP ARTHROPLASTY OPERATIVE FORM
Registry Form

Name: _____

MRN: _____

Imprint Area

SURGEON	DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION: ☐HI ☐HI_OTHER
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)**
- ☐**Rheumatoid arthritis (RA)**
- ☐**Inflammatory arthritis (Non-RA)**
- ☐**Post traumatic arthritis**
- ☐Aseptic loosening
- ☐Component fracture
- ☐Cup malposition
- ☐Dysplasia
- ☐Failed hemiarthroplasty
- ☐Failed ORIF
- ☐Heterotopic Ossification
- ☐Infection
- ☐Instability
- ☐Liner wear
- ☐LLD (Leg Length Discrepancy)
- ☐Metallosis
- ☐Osteolysis
- ☐Osteonecrosis/Avascular necrosis
- ☐Pain
- ☐Peri-prosthetic fracture of _____
- ☐Seroma/Hematoma
- ☐Wound dehiscence
- ☐Wound drainage
- ☐Other _____

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

Procedure *(Check all that apply)*

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