

V 1.2

# West Bengal Joint Registry

## S1 Shoulder Primary

Patient Addressograph

**Important:**

Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Dataset Form Component Labels Sheet'. Please ensure that all sheets are stapled together.

All fields are Mandatory unless otherwise indicated

### PATIENT DETAILS

Patient Consent Obtained for Registry?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Recorded <input type="checkbox"/>
Patient Hospital ID			
Body Mass Index (enter either H&W OR BMI OR tick Not Available box)	Height (in Centimeters)	BMI	Not Available <input type="checkbox"/>
Handedness	Weight (in Kilograms)	Left <input type="checkbox"/>	Right <input type="checkbox"/>
		Ambidextrous <input type="checkbox"/>	Unknown <input type="checkbox"/>

### PATIENT IDENTIFIERS

Full Name			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Date of Birth	Age (In Years) :		
Contact Details (optional)	Mobile :	Residence Phone :	
	Email :		
Full Address (optional*) Please provide city.			
Patient Pincode (optional)	Overseas Address <input type="checkbox"/>		
Identification Type (optional)	PAN <input type="checkbox"/>	Aadhaar <input type="checkbox"/>	Passport (For Overseas Citizen) <input type="checkbox"/>
		Other <input type="checkbox"/>	
Patient Identification Number (optional)			

OPERATION DETAILS	
Hospital	
Operation Date	
Anaesthetic Types(select all that apply)	General <input type="checkbox"/> Regional- Nerve Block <input type="checkbox"/>
Patient ASA Grade	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Operation Funding	Insurance <input type="checkbox"/> Self <input type="checkbox"/> Insurance + Self <input type="checkbox"/> Government Sponsor <input type="checkbox"/> Other <input type="checkbox"/>

SURGEON DETAILS	
Consultant in Charge	MCR <sup>1</sup> Number : Name:
Operating Surgeon (if different than above)	MCR <sup>1</sup> Number : Name:
Operating Surgeon Grade	Consultant <input type="checkbox"/> Associate Consultant <input type="checkbox"/> Senior Registrar <input type="checkbox"/> Other <input type="checkbox"/>
First Assistant Grade	Consultant <input type="checkbox"/> Associate Consultant <input type="checkbox"/> Senior Registrar <input type="checkbox"/> Other <input type="checkbox"/>

\*1 - (MCR) - Medical Council Registration number

**SHOULDER PRIMARY PROCEDURE DETAILS**

Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Indications for Implantation (select all that apply)	Osteoarthritis <input type="checkbox"/> Avascular Necrosis (AVN) <input type="checkbox"/> Cuff Tear Arthropathy <input type="checkbox"/> Cuff Tear without Arthropathy <input type="checkbox"/> Acute Fracture <input type="checkbox"/>	Inflammatory Arthropathy <input type="checkbox"/> Trauma Sequelae <input type="checkbox"/> Metastatic Cancer/Malignancy <input type="checkbox"/> Dislocation Arthropathy <input type="checkbox"/> Other <input type="checkbox"/>
Previous surgery (not arthroplasty) (Select all that apply)	None <input type="checkbox"/> For Fracture <input type="checkbox"/> For Instability <input type="checkbox"/> For Impingement <input type="checkbox"/>	For Cuff Tear <input type="checkbox"/> For Gleno-humeral Arthritis <input type="checkbox"/> Previous Arthrodesis <input type="checkbox"/> Other <input type="checkbox"/>

**SURGICAL APPROACH**

Patient Procedure	Stemmed Conventional Total Arthroplasty <input type="checkbox"/> Stemmed Hemi-arthroplasty <input type="checkbox"/> Stemmed Total Reverse Arthroplasty <input type="checkbox"/> Interpositional Arthroplasty (Glenohumeral) <input type="checkbox"/>
Fixation Humerus	Uncemented <input type="checkbox"/> Cemented <input type="checkbox"/> Not applicable <input type="checkbox"/>
Fixation Glenoid	Uncemented <input type="checkbox"/> Cemented <input type="checkbox"/> Not applicable <input type="checkbox"/>
Approach	Delto-pectoral <input type="checkbox"/> Trans-deltoid <input type="checkbox"/> Other <input type="checkbox"/>
Patient specific instruments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Computer Guided Surgery Used?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**THROMBOPROPHYLAXIS REGIME (intention to treat)**

Chemical (In Hospital)	Aspirin <input type="checkbox"/> LMWH <input type="checkbox"/> Pentasaccharide (e.g. Fondaparinux) <input type="checkbox"/> Warfarin <input type="checkbox"/>	Direct Thrombin Inhibitor (e.g. Dabigatran) <input type="checkbox"/> Factor Xa Inhibitor (e.g. Rivaroxaban/Apixaban) <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/>
Mechanical	Foot Pump <input type="checkbox"/> Intermittent Calf Compression <input type="checkbox"/> TED Stockings <input type="checkbox"/>	Other <input type="checkbox"/> None <input type="checkbox"/>

**BONE GRAFT USED**

Was Bone graft used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Rotator Cuff						
Rotator Cuff Condition	Normal	<input type="checkbox"/>	Attenuated	<input type="checkbox"/>	Absent/Torn	<input type="checkbox"/>
Rotator Cuff Repaired?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Repair Type	Primary Repair	<input type="checkbox"/>	Augmented Patch Repair	<input type="checkbox"/>		

Other Soft Tissues						
Long Head Biceps (LHB) Present?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
LHB Tenotomy Performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
LHB Tenodesis Performed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Muscle Transfer?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Other?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		

SURGEON'S NOTES

INTRA-OPERATIVE EVENT						
Untoward Intra-Operative Event	None	<input type="checkbox"/>	Fracture Glenoid	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Fracture Humerus	<input type="checkbox"/>	Vascular Injury	<input type="checkbox"/>		

**PRE-OPERATIVE OXFORD SCORES – Tick one box for every question. If no scores available select Pre-operative Oxford Scores Not available**

Pre-operative Oxford Score Date	DD/MM/YYYY	Not available <input type="checkbox"/>
1. During the past 4 weeks... How would you describe the <b>worst</b> pain you had <u>from your shoulder</u> ?		Not available <input type="checkbox"/>
None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>
Severe <input type="checkbox"/>	Unbearable <input type="checkbox"/>	
2. During the past 4 weeks... Have you had any trouble dressing yourself <u>because of your shoulder</u> ?		Not available <input type="checkbox"/>
No trouble at all <input type="checkbox"/>	A little bit of trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>
Extreme difficulty <input type="checkbox"/>	Impossible to do <input type="checkbox"/>	
3. During the past 4 weeks... Have you had any trouble getting in and out of a car or using public transport <u>because of your shoulder</u> ?		Not available <input type="checkbox"/>
No trouble at all <input type="checkbox"/>	A little bit of trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>
Extreme difficulty <input type="checkbox"/>	Impossible to do <input type="checkbox"/>	
4. During the past 4 weeks... Have you been able to use a knife and fork <u>at the same time</u> ?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With extreme difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
5. During the past 4 weeks... Could you do the household shopping <u>on your own</u> ?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With extreme difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
6. During the past 4 weeks... Could you carry a tray containing a plate of food across a room?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With extreme difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
7. During the past 4 weeks... Could you brush/comb your hair <u>with the affected arm</u> ?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With extreme difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
8. During the past 4 weeks... How would you describe the pain you <u>usually</u> had from your shoulder?		Not available <input type="checkbox"/>
None <input type="checkbox"/>	Very mild <input type="checkbox"/>	Mild <input type="checkbox"/>
Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	
9. During the past 4 weeks... Could you hang your clothes up in a wardrobe, <u>using the affected arm</u> ?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With great difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
10. During the past 4 weeks... Have you been able to wash and dry yourself under both arms?		Not available <input type="checkbox"/>
Yes, easily <input type="checkbox"/>	With little difficulty <input type="checkbox"/>	With moderate difficulty <input type="checkbox"/>
With extreme difficulty <input type="checkbox"/>	No, impossible <input type="checkbox"/>	
11. During the past 4 weeks... How much has <u>pain from your shoulder</u> interfered with your usual work (including housework)?		Not available <input type="checkbox"/>
Not at all <input type="checkbox"/>	A little bit <input type="checkbox"/>	Moderately <input type="checkbox"/>
Greatly <input type="checkbox"/>	Totally <input type="checkbox"/>	
12. During the past 4 weeks... Have you been troubled by <u>pain from your shoulder</u> in bed at night?		Not available <input type="checkbox"/>
No nights <input type="checkbox"/>	Only 1 or 2 nights <input type="checkbox"/>	Some nights <input type="checkbox"/>
Most nights <input type="checkbox"/>	Every night <input type="checkbox"/>	

# Minimum Dataset Form - COMPONENT LABELS