



# INDIAN SOCIETY OF HIP & KNEE SURGEONS

## HIP FORM

(Please complete both sides of this form.)

### FEMORAL COMPONENTS

(Mark boxes, place company labels or complete details by hand)

None  Stem  Head  Centraliser  Intra-medullary  Plug

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

**FEMORAL CEMENT**                      **NO**                       **YES**

**FEMORAL CEMENTING :**    **Gun**     **Hand Packing**

**CEMENT NAME :** .....

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

**COMPUTER ASSISTED :**    **NO**                       **YES**

System used : .....

**COMMENTS or extra labels :**

**All sections of the form MUST be completed**



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## HIP FORM

### Place Patients Details Label here

And / or if any patient details required are not available on the hospital label, please complete below

Surname : ..... Female :  Male :   
First Name : ..... Middle Initial : .....  
Age : ..... Weight : ..... Height : .....  
Address : (Optional) : .....  
..... Pin Code : .....  
Hospital Patient No. : ..... (Optional / Indoor No.)

Name of Hospital (Optional) : ..... State : .....  
Consultant Surgeon Code (inclusion of surgeon code is optional) : .....

**(All of this section MUST be completed)** (Complete operation date & mark boxes)

**OPERATION DATE :**     /     /     (If bilateral use 2 forms) **L**  **R**

**PRIMARY**

Dose not include Hemi Arthroplasty,  
Bipolar Arthroplasty

#### PRIMARY PROCEDURE

Cemented  Uncemented  Hybrid

Resurfacing  Any Other

Avascular Necrosis

Anky. Spondylitis

Rheumatoid Arthritis

Failed Hemiarthroplasty

Fracture Dislocation

Faild TC, IT Fractures

Dysplasia

Fresh Fracture Neck

Primary O. A.

Tumour

Other (Please specify)

**REVISION**

Includes : removal, exchange or addition of  
one or more components

#### DIAGNOSIS

(Tick more than one box if applicable)

Loosening

Lysis

Dislocation

Infection

Implant breakage : stem  acetabular

Fracture : (specify below)  
.....

Other : (specify below)  
.....

Previous Implant (Company & Model)  
.....

### ACETABULAR COMPONENTS

(Mark boxes, place company labels on the coloured areas or complete details by hand)

None  Cup  Shell  Insert  Reinforcement Ring  Struct. Graft

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

Company : .....

Prosthesis Name : .....

Cat / Ref. No. : .....

Lot No. : .....

**ACETABULAR CEMENT**    NO     YES

**CEMENT NAME :** .....

(Use Company Label or complete details : If more than one mix is used, use only 1 label)

(complete by hand, labels not required)

**SCREWS :**    NO     YES     Number .....