

Knee Arthroplasty Registry

Demographic information	General issues	Laboratory Results (Before Surgery)
Patient ID: National ID: Cellphone: Province: City: Gender: <input type="radio"/> Male <input type="radio"/> Female Birth year: Weight: Height: Marital Status: <input type="radio"/> Married <input type="radio"/> Single Economic Level: <input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High Smoking: <input type="radio"/> yes <input type="radio"/> No	Type of Arthroplasty: <input type="radio"/> Primary <input type="radio"/> Revision <input type="radio"/> TKA: <input type="radio"/> PS <input type="radio"/> CR <input type="radio"/> with Patella <input type="radio"/> Without Patella <input type="radio"/> UKA: <input type="radio"/> Medial <input type="radio"/> Lateral <input type="radio"/> CCK <input type="radio"/> RHK <input type="radio"/> Tumor Prosthesis Side: <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both Reason for Primary Arthroplasty: <input type="checkbox"/> OA <input type="checkbox"/> RA <input type="checkbox"/> Fracture (Less than 3 months) <input type="checkbox"/> Fracture sequelae (damage by earlier fracture) <input type="checkbox"/> Osteonecrosis <input type="checkbox"/> Tumor <input type="checkbox"/> Infection Reason for Revision Arthroplasty: <input type="checkbox"/> Loosening: <input type="checkbox"/> Periprosthetic fracture: <input type="checkbox"/> Fracture of component: <input type="checkbox"/> infection <input type="checkbox"/> Instability	W.B.C: HCT: Hgb: LYMPH: PMN: CRP: ESR: <div style="background-color: #2c3e50; color: white; text-align: center; padding: 5px;">Anesthesia</div> Type of Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <div style="background-color: #2c3e50; color: white; text-align: center; padding: 5px;">Surgery</div> Time of Operation: <input type="radio"/> < 2 Hours <input type="radio"/> > 2 Hours Transamin: <input type="radio"/> No <input type="radio"/> Yes Approach: <input type="radio"/> parapatellar <input type="radio"/> Subvastus <input type="radio"/> Midvastus Tourniquet: <input type="radio"/> No <input type="radio"/> Yes Washing method of operation site: <input type="radio"/> Pulse lavage <input type="radio"/> With syringe and serum Adverse intraoperative event: <input type="checkbox"/> Fracture <input type="checkbox"/> Nerve Injury <input type="checkbox"/> Vascular Injury <input type="checkbox"/> Ligament injury <input type="checkbox"/> Tendon Injury Blood transfusions during surgery? <input type="radio"/> No <input type="radio"/> Yes
Hospitalization		
Hospital Name: Akhtar Province: Tehran Surgeon: Assistant: Date of Admission: Date of Surgery: Date of discharge: Length of preoperative hospital stay: Postoperative hospital stay:	<div style="background-color: #2c3e50; color: white; text-align: center; padding: 5px;">Knee status</div> KSS (Before surgery): KSS (After surgery):	

<p>Wound closure:</p> <p><input type="radio"/> with tourniquet</p> <p><input type="radio"/> without tourniquet</p> <p>Type of suture:</p> <p>Retinaculum:</p> <p><input type="radio"/> Continuous <input type="radio"/> Separate</p> <p>Subcutaneous:</p> <p><input type="radio"/> Continuous <input type="radio"/> Separate</p> <p>Cutaneous:</p> <p><input type="radio"/> Continuous <input type="radio"/> Separate</p>	<p>Size: <input type="radio"/> 5mm <input type="radio"/> 10mm</p> <p>Metal augment Femur:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p> <p><input type="checkbox"/> Distal:</p> <p><input type="radio"/> 5mm <input type="radio"/> 10mm <input type="radio"/> 15mm</p> <p><input type="checkbox"/> Posterior:</p> <p><input type="radio"/> 5mm <input type="radio"/> 10mm <input type="radio"/> 15mm</p> <p>Cone: <input type="radio"/> No <input type="radio"/> Yes</p> <p>Tibial cone:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p>	<p style="text-align: center;">Post operation in the ward</p> <p>Antibiotic:</p> <p><input type="checkbox"/> Cefazolin <input type="checkbox"/> Vancomycin</p> <p><input type="checkbox"/> Meropenem <input type="checkbox"/> Ceftriaxone</p> <p><input type="checkbox"/> Clindamycin</p> <p>Surgical drain: <input type="radio"/> No <input type="radio"/> Yes</p> <p>Blood transfusions? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Anticoagulant:</p> <p><input type="checkbox"/> Enoxaparin <input type="checkbox"/> ASA</p> <p><input type="checkbox"/> Warfarin <input type="checkbox"/> Rivaroxaban</p> <p>Mechanical anti DVT:</p> <p><input type="checkbox"/> T.E.D Stocking <input type="checkbox"/> Foot Pump</p> <p><input type="checkbox"/> Intermittent Calf Compression</p>
Detail of prosthesis		
<p>Brand:</p> <p>Size:</p> <p>Size of Tibial component:</p> <p>Size of femoral component:</p> <p>Size of Poly:</p> <p>Femoral component stem:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p> <p>Type of stem:</p> <p><input type="radio"/> Cemented stem</p> <p><input type="radio"/> Cementless stem</p> <p>Tibial component stem:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p> <p>Type of stem:</p> <p><input type="radio"/> Cemented stem</p> <p><input type="radio"/> Cementless stem</p> <p>Metal augment Tibia:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p> <p>Type:</p> <p><input type="radio"/> Half <input type="radio"/> Full</p>	<p>Type:</p> <p><input type="radio"/> Diaphysis <input type="radio"/> metaphyseal</p> <p>Size: <input type="radio"/> Small <input type="radio"/> Medium <input type="radio"/> Large</p> <p>Femoral cone:</p> <p><input type="radio"/> No <input type="radio"/> Yes If yes:</p> <p>Type:</p> <p><input type="radio"/> Diaphysis <input type="radio"/> metaphyseal</p> <p>Size:</p> <p><input type="radio"/> Small <input type="radio"/> Medium <input type="radio"/> Large</p> <p>Type of constrain:</p> <p><input type="radio"/> CR <input type="radio"/> PS <input type="radio"/> CCK <input type="radio"/> RHK</p> <p>Cement type:</p> <p><input type="radio"/> With Antibiotic</p> <p><input type="radio"/> Without Antibiotic</p> <p>Cementing Technique:</p> <p><input type="checkbox"/> Vacuum mixing</p> <p><input type="checkbox"/> Cement restrictor</p> <p><input type="checkbox"/> Stem centralizer</p> <p><input type="checkbox"/> Pulse Lavage</p> <p><input type="checkbox"/> Cement gun</p> <p><input type="checkbox"/> Proximal pressurizer</p>	<p style="text-align: center;">Laboratory Results (After Surgery)</p> <p>W.B.C: <input type="text"/> HCT: <input type="text"/></p> <p>Hgb: <input type="text"/> LYMPH: <input type="text"/></p> <p>PMN: <input type="text"/> CRP: <input type="text"/></p> <p>ESR: <input type="text"/></p> <p style="text-align: center;">Discharge Note</p> <p>Brace in walking: <input type="radio"/> No <input type="radio"/> Yes</p> <p>Walker: <input type="radio"/> No <input type="radio"/> Yes</p> <p>Crutch: <input type="radio"/> No <input type="radio"/> Yes</p> <p>Duration of taking Anticoagulant:</p> <p><input type="radio"/> 1 week <input type="radio"/> 2 week</p> <p><input type="radio"/> 4 week <input type="radio"/> 6 week</p> <p>Type Of weight bearing:</p> <p><input type="radio"/> Non weight bearing</p> <p><input type="radio"/> Partial weight bearing</p> <p><input type="radio"/> Full weight bearing</p>