



Knee Primary

Knee Primary:
Replacement of
knee joint by a
prosthetic implant

Version: January 1, 2014

patientsticker

Patient

Hospital number _____ Social Security Number _____
Postal code (numbers) _____ Length (cm) _____ Weight (kg) _____
Smoking No Yes BMI* _____
* Please fill out 'length' and 'weight' or Body Mass Index (BMI)

Diagnosis

Diagnosis¹ Osteoarthritis (OA) Tumour (primary)
 Posttraumatic Tumour (metastasis)
 Rheumatoid arthritis (RA) Inflammatory arthritis
 Osteonecrosis Other diagnosis, specify _____
¹ Explanation of variable DIAGNOSIS on other side of this form

ASA classification I Normal healthy patient
 II Patient with mild systemic disease
 III Patient with severe systemic disease that is limiting but not incapacitating
 IV Patient with incapacitating disease that is a constant threat to life

Charnley score A Single Knee with OA
 B1 Bilateral Knees with OA
 B2 Previous Total Knee Replacement on the contralateral knee
 C Multiple joints affected with OA or a chronic disease that affects quality of life (especially walking)

Type of operation

Date of operation _____ Surgeon code* _____
Assistant surgeon code* _____
* Unique number per surgeon (Chosen and known within the hospital) OR BIG-number.

Side of operation Right Left

Prosthesis Unicondylar Knee Prosthesis Patellofemoral Knee Prosthesis
 Total Knee Prosthesis Other prosthesis, specify _____

If unicondylar, type Medial Lateral

Approach Medial parapatellar Vastus (mid/sub)
 Lateral parapatellar Other approach, specify _____

Tuberositas Osteotomy No Yes

Bone graft used² No Yes, autograft Yes, allograft Yes, combination of both

Patella component No Yes

Previous operations (this knee)³

Meniscectomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Synovectomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Osteotomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Arthroscopy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ACL-reconstruction	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Patella realignment procedure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Osteosynthesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Other previous operations	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Cement⁴

Fixation Cementless Hybrid Cemented

Lavage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If hybrid fixation,		
Vacuum (mix)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Femur cemented	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pressurising	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tibia cemented	<input type="checkbox"/> No	<input type="checkbox"/> Yes
			Patella cemented	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Attach sticker cement

Attach sticker femoral component (only articulating component)

Attach sticker tibia component (tibial baseplate, monoblock)

Attach sticker inlay (bearing, insert)

Attach sticker patella (only articulating component)



Do not register any other components like: stem extensions, augmentations, sleeves, necks, cables, claws, screws, head adapters, wedges, spacers, etc.

