



**TOTAL KNEE ARTHROPLASTY  
OPERATIVE FORM  
Registry Form**

Name: \_\_\_\_\_

MRN: \_\_\_\_\_

Imprint Area

SURGEON	DOB (MM/DD/YY)	PLEASE CHECK YOUR LOCATION: <input type="checkbox"/> KSMC <input type="checkbox"/> KWMC <input type="checkbox"/> NW_OTHER
OPERATIVE DATE (MM/DD/YY) / /	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

**Operative Side:**  Left  Right **Same day bilateral procedure?**  No  Yes *If yes,*  Sequential (1 surgeon)  Simultaneous (2 surgeons)

**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

**Tourniquet Time:** \_\_\_\_\_ mins **Pressure:** \_\_\_\_\_ mmHg

**Drain:**  Reinfusion  Non-Reinfusion  None

**Reason for surgery (Check all that apply)**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Osteoarthritis (OA)             | <input type="checkbox"/> Failed Ext. Mech. | <input type="checkbox"/> Ingrowth failure                 | <input type="checkbox"/> Infection            |
| <input type="checkbox"/> Rheumatoid arthritis (RA)       | <input type="checkbox"/> Failed HTO        | <input type="checkbox"/> Instability                      | <input type="checkbox"/> Seroma/Hematoma      |
| <input type="checkbox"/> Inflammatory arthritis (Non-RA) | <input type="checkbox"/> Failed ORIF       | <input type="checkbox"/> Liner wear                       | <input type="checkbox"/> Synovial impingement |
| <input type="checkbox"/> Post traumatic arthritis        | <input type="checkbox"/> Failed UKA        | <input type="checkbox"/> Osteolysis                       | <input type="checkbox"/> Wound dehiscence     |
| <input type="checkbox"/> Arthrofibrosis                  | <input type="checkbox"/> Failed Uni-spacer | <input type="checkbox"/> Osteonecrosis/Avascular necrosis | <input type="checkbox"/> Wound drainage       |
| <input type="checkbox"/> Aseptic loosening               | <input type="checkbox"/> Femoral fracture  | <input type="checkbox"/> Pain                             | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Component fracture              | <input type="checkbox"/> Tibial fracture   | <input type="checkbox"/> PF joint malfunction             |   |

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

**Procedure (Check all that apply)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> TKA with patella                | <input type="checkbox"/> HWR                 | <input type="checkbox"/> Revision femur                  | <input type="checkbox"/> RAS (Robotic Assisted Surgery) |
| <input type="checkbox"/> TKA without patella             | <input type="checkbox"/> I&D                 | <input type="checkbox"/> Revision patella                | <input type="checkbox"/> Zimmer-ROSA                    |
| <input type="checkbox"/> TKA revision                    | <input type="checkbox"/> Liner exchange      | <input type="checkbox"/> Revision tibia                  | <input type="checkbox"/> SmithNephew-CORI               |
| <input type="checkbox"/> TKA revision                    | <input type="checkbox"/> MUA                 | <input type="checkbox"/> Stage 1 – explantation          | <input type="checkbox"/> Depuy-VELYS                    |
| <input type="checkbox"/> UKA (medial)                    | <input type="checkbox"/> ORIF changed to TKA | <input type="checkbox"/> Stage 2 – reimplantation        | <input type="checkbox"/> Stryker-MAKO                   |
| <input type="checkbox"/> UKA (lateral)                   | <input type="checkbox"/> ORIF of _____       | <input type="checkbox"/> Synovectomy                     | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> UKA converted to TKA            | <input type="checkbox"/> Other: _____        | <input type="checkbox"/> CAS (Computer Assisted Surgery) | <input type="checkbox"/> RAS Version: _____             |
| <input type="checkbox"/> Patellofemoral uni/arthroplasty |  |  |   |

**Cement:**  None  All  Patella  Tibia  Femur

**Bone graft:**  None  Non-Structural  Structural **(Specify location):**  Tibia  Femur

**Soft Tissue Releases:** Lateral retinaculum (patellar tracking)  Yes  No

**Exposure:**  Mid-vastus  Parapatellar  Sub-vastus  Tubercle osteotomy  
 Mini  Quadriceps release  Trivector  Other \_\_\_\_\_

**Intra-op Complications?**  Yes  No **If yes, specify** \_\_\_\_\_

**VTE-Prophylaxis: (List all anticipated)**

- |   |   |                                    |  |                                      |
|---|---|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Coumadin                     | <input type="checkbox"/> Arixtra (fondaparinux) | <input type="checkbox"/> Foot pump | <input type="checkbox"/> TED hose              | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Low molecular weight heparin | <input type="checkbox"/> Aspirin                | <input type="checkbox"/> SCD       | <input type="checkbox"/> Xarelto (rivaroxaban) |                                      |

SIGNATURES: \_\_\_\_\_

DATE: \_\_\_\_\_

Please scan & email to [implantregistries-forms@kp.org](mailto:implantregistries-forms@kp.org); or secure efax to 844-527-0153.

***PLACE IMPLANT STICKERS HERE***

**Femoral Component**

**Tibial Tray**

**Tibial Insert**

**Patella**

**Cement**

**Screws**