Hospital: **State / Territory:**

Date data collection commenced: __ __ /__ __ /__ __ __ __

1. Demographic Information (label if available)

Name	Street Address	Suburb and Postcode
Date of Birth	**Sex**	**Hospital MRN**
__ __ /__ __ /__ __ __ __	□ Male □ Female	
Telephone Numbers(s)	**Height measured (m)**	**Weight measured (kg)**
Email Address:		
Other Contact Person: Name/Relationship/Telephone		

Health Insurance for Surgery

o Public hospital insurance o Private health insurance o Self funded
o Other third party payer o Workers' compensation insurance o Other compensation payer
o DVA o Other o Unknown

Preferred Language

How well do you speak English? (tick only one) o Very well o Well o Not very well o Not at all

In what language do you prefer your medical care? o English o Other (please specify)

Highest Year of School Completed

o Year 12 o Year 11 o Year 10 o Year 9 o Year 8 or below o No schooling o Unknown

Highest Non-School Qualification

o Trade Certificate o Advanced Diploma/Diploma o Graduate Diploma/Graduate Certificate
o Bachelor Degree o Postgraduate Degree o None o Unknown

2. Expectations after Surgery

Level of Pain 6-months after Surgery

What are your expectations of your **knee/hip pain** six months after your surgery?

o No pain o Slight pain o Moderate pain o Severe pain

Functional Ability 6-months after Surgery

What are your expectations of your **functional ability** six months after your surgery?

o No limitation o Some limitation o Moderate limitation o Severe limitation

3. Medical History

Previous hip or knee replacement – please tick all that apply to you

o Only right hip o Only left hip o Both hips o I have never had any hip replaced before
o Only right knee o Only left knee o Both knees o I have never had any knee replaced before

Low back problems or other lower limb joint problems

o I have low back problems that interfere with my mobility o I do not have low back problems
o I have other joint problems in my leg(s) that interfere with my mobility o I do not have other joint problems

PLEASE CONTINUE THIS SECTION OVER THE PAGE…

Have you ever been told by a Doctor you have any of the following conditions			
Heart disease, such as AF, high cholesterol, other	Yes / No	If yes, do you take **daily** medication	Yes / No
High blood pressure	Yes / No	If yes, do you take **daily** medication	Yes / No
Diabetes	Yes / No	If yes, do you take **daily** medication	Yes / No
GIT or Stomach Condition	Yes / No	If yes, do you take **daily** medication	Yes / No
Lung Condition	Yes / No	If yes, do you take **daily** medication	Yes / No
Kidney Condition	Yes / No	If yes, do you take **daily** medication	Yes / No
Liver Condition or Disease	Yes / No	If yes, do you take **daily** medication	Yes / No
Neurological Condition or Disease	Yes / No	If yes, do you take **daily** medication	Yes / No
Anxiety or Depression	Yes / No	If yes, do you take **daily** medication	Yes / No
OR o I have never been told by a Doctor I have any of the conditions listed above			

Thank you. Section 4 below is to be completed by hospital staff.

4. Surgical and Acute Admission Details

Date of Admission	**Date of Surgery**	**ASA Score**
__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __	o 1 o 2 o 3 o 4 o 5
Joint to be Replaced during Index Admission		**Surgeon Name**
o Right hip o Left hip o Both hips o Right knee o Left knee o Both knees		

Surgery Type and Reason	
o **Primary** joint replacement o OA o RA o DDH o Other inflammatory arthritis o Osteonecrosis/AVN o Tumour o Other (specify)	o **Revision** joint replacement o Loosening o Lysis o Dislocation o Implant breakage o Infection o Fracture o Other (specify)

ICU / HDU Admission

o Yes, admitted to a high care bed If yes, o Planned admission OR o Unplanned admission
o Not admitted to a high care bed

Blood Transfusion

o No o Yes If yes, o Donor OR o Autologous Number of units:

Complications During Index Admission

o Yes (select as many from the list below as apply) o No complications
o Bladder infection o Bladder retention o CVS (stroke, MI, arrhythmia) o Delirium o Dislocation
o DVT o Fracture o Nerve Injury o PE o Reoperation
o Respiratory Infection o Surgical Site Infection (SSI) o Other (specify)

Discharge Destination	**Date of Discharge (from ward)** __ __ /__ __ /__ __ __ __
o Usual residence / residence of relative/friend	o Inpatient rehabilitation (same hospital)
o Inpatient rehabilitation (other hospital)	o Hostel (if not usual place of residence)
o Nursing home (if not usual place of residence)	o Another acute hospital
o Other (specify)	

Site Coordinator Checklist

Participant Information Sheet provided?	o Yes	o No	Oxford Score completed and attached	o Yes	o No
Has the participant opted-out?	o Yes	o No	EQ5D/EQVAS completed and attached	o Yes	o No