

EFORT Minimal Dataset Hip Arthroplasty Revision Form



Date of Revision:
Number of Revision:

Clinic/Country:

<u>Patient:</u>	Name:	Prenome:	Birthday:
	Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F
	ID-Number:		

Primary Implant:

- Total HA
- Bipolar HA
- Partial HA

Right

Left

<u>Acetabular Component:</u>			
Type:	<i>Databank or scroll menu</i>		Manufacturer: <i>Databank or scroll menu</i>
Cemented:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<u>Inlay:</u>	<i>Databank or scroll menu</i>	PE	Ceramic Metal
<u>Head:</u>	<i>Databank or scroll menu</i>	Ceramic	Metal
<u>Femoral component:</u> <i>Databank or scroll menu</i>			
Type:	<i>Databank or scroll menu</i>		Manufacturer: <i>Databank or scroll menu</i>
Cemented	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Date of primary Operation:

Clinic/Dept.:

