

Hospital

State / Terr / NZ

<b>First Name</b>	<b>Surname</b>	<b>Patient's postcode</b>
_____	_____	_____
<b>Date of Birth</b>	<b>Gender</b>	<b>Ethnic Status</b>
___/___/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> European <input type="checkbox"/> Māori <input type="checkbox"/> Pacific Peoples <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern/ Latin American/ African <input type="checkbox"/> Other Ethnicity <input type="checkbox"/> Not elsewhere included
<b>Hospital Event Number</b>	<b>Contact telephone number</b>	
_____	_____	
<b>National Health Index</b>	<b>Payment status</b>	
_____	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Overseas / other	

<b>Admission via ED of operating hospital</b>	<b>If transferred from another hospital</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No, transferred from another hospital <input type="checkbox"/> No, in-patient fall <input type="checkbox"/> Other / not known	Name of transferring hospital: _____ ED/Hospital arrival date: ___/___/_____ :__hrs Record time using 24hr clock
<b>If admitted via ED</b>	<b>If an in-patient fall (time using 24hr clock)</b>
Admission ___/___/_____ :__hrs  Departure ___/___/_____ :__hrs (from ED) Record time using 24hr clock	Date / time of diagnosis ___/___/_____ :__hrs  Record time using 24hr clock
<b>Admitted from</b>	<b>Type of ward admitted to</b>
<input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Other <input type="checkbox"/> Not known Note: If holiday residence/respite care, document usual place of residence	<input type="checkbox"/> Hip fracture unit /Orthopaedic ward / preferred ward <input type="checkbox"/> Outlying ward <input type="checkbox"/> HDU / CCU / ICU <input type="checkbox"/> Other / not known

<b>Pain Assessment</b>	<b>Pain Management</b>	
<input type="checkbox"/> Documented assessment of pain within 30 minutes of ED presentation <input type="checkbox"/> Documented assessment of pain greater than 30 minutes of ED presentation <input type="checkbox"/> Pain assessment not documented or not done <input type="checkbox"/> Not known or recorded	<input type="checkbox"/> Analgesia given within 30 minutes of ED presentation <input type="checkbox"/> Analgesia given more than 30 minutes after ED presentation <input type="checkbox"/> Analgesia provided by paramedics <input type="checkbox"/> Analgesia not required <input type="checkbox"/> Not known	
<b>Walking ability pre-admission</b>	<b>Pre-operative cognitive assessment</b>	<b>Pre-operative cognitive status</b>
<input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair or chair/bed bound <input type="checkbox"/> Not known	<input type="checkbox"/> Cognition assessed using validated tool and recorded <input type="checkbox"/> Cognition not assessed <input type="checkbox"/> Not known	<input type="checkbox"/> Normal cognition <input type="checkbox"/> Impaired cognition or known dementia <input type="checkbox"/> Not assessed <input type="checkbox"/> Not known or recorded
<b>Bone protection medication at admission</b>	<b>Pre-operative medical assessment</b>	
<input type="checkbox"/> No bone protection medication <input type="checkbox"/> Yes, calcium and/or vitamin D only <input type="checkbox"/> Yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known	<input type="checkbox"/> No assessment conducted <input type="checkbox"/> Geriatrician / geriatric team <input type="checkbox"/> Physician / physician team <input type="checkbox"/> GP <input type="checkbox"/> Specialist nurse <input type="checkbox"/> Not known This is in addition to preoperative anaesthetic and orthopaedic review	
<b>Side of fracture</b>	<b>Type of fracture</b>	
<input type="checkbox"/> Left <input type="checkbox"/> Right  If bilateral – complete a separate record for each fracture	<input type="checkbox"/> Intracapsular – undisplaced / impacted <input type="checkbox"/> Intracapsular - displaced <input type="checkbox"/> Per / intertrochanteric <input type="checkbox"/> Subtrochanteric  Note: Basal/basicervical #s are to be classed as per/intertrochanteric	

<b>Atypical fracture</b>	<b>Did the patient undergo surgery</b>
<input type="checkbox"/> Not a pathological or atypical fracture <input type="checkbox"/> Pathological fracture <input type="checkbox"/> Atypical fracture See data dictionary if uncertain of definitions	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Date &amp; time of primary surgery</b>	<b>ASA grade</b>
____ / ____ / _____    ____:____hrs Record time using 24hr clock	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> unknown

<b>Reason if delay &gt; 48 hours</b>	<b>Operation Performed</b>
<input type="checkbox"/> No delay- surgery < 48 hrs <input type="checkbox"/> Yes, delayed due to patient deemed medically unfit <input type="checkbox"/> Yes, delayed due to issues with anticoagulation <input type="checkbox"/> Yes, delayed due to theatre availability <input type="checkbox"/> Yes, delayed due to surgeon availability <input type="checkbox"/> Yes, delayed due to delayed diagnosis of hip fracture <input type="checkbox"/> Other type of delay (state reason) <input type="checkbox"/> Not known  Note: Delay is calculated from time of presentation to ED or diagnosis of hip fracture for those transferred from other hospital or in-patient fall	<input type="checkbox"/> Cannulated screws <input type="checkbox"/> Sliding hip screw <input type="checkbox"/> IM nail – short <input type="checkbox"/> IM nail – long <input type="checkbox"/> Hemiarthroplasty, cemented stem <input type="checkbox"/> Hemiarthroplasty, uncemented stem <input type="checkbox"/> THR, cemented stem <input type="checkbox"/> THR, uncemented stem <input type="checkbox"/> Other <input type="checkbox"/> Not known

<b>Anaesthesia</b>	<b>Analgesia (nerve block)</b>
<input type="checkbox"/> General anaesthetic <input type="checkbox"/> Spinal / regional anaesthesia <input type="checkbox"/> General and spinal/regional anaesthesia <input type="checkbox"/> Other – state <input type="checkbox"/> Not known	<input type="checkbox"/> Nerve block administered preoperative (before arriving in OT) <input type="checkbox"/> Nerve block administered in OT <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Not known

<b>Consultant present during surgery</b>	<b>Postoperative weight bearing status</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Not known

<b>First day mobilisation</b>	<b>New Pressure Injury of the skin</b>
<input type="checkbox"/> Patient out of bed and given opportunity to start mobilising day 1 post surgery <input type="checkbox"/> Patient not given opportunity to start mobilising day 1 post surgery <input type="checkbox"/> Not known	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known  Note: Grade 2 + above during acute admission

<b>Assessed by Geriatrician in acute phase of care</b>	<b>Date initially assessed by Geriatrician</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No geriatric medicine service available <input type="checkbox"/> Not known	____ / ____ / _____

<b>Specialist falls assessment</b>	<b>Bone protection medication at discharge from operating hospital</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes - performed during admission <input type="checkbox"/> Yes - awaits falls clinic assessment <input type="checkbox"/> Yes - further intervention not appropriate <input type="checkbox"/> Not relevant, eg patient died <input type="checkbox"/> Not known	<input type="checkbox"/> No bone protection medication <input type="checkbox"/> Yes, calcium and/or vitamin D only <input type="checkbox"/> Yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known

<b>Date of discharge from acute / orthopaedic ward</b>	<b>Discharge destination from acute / orthopaedic ward</b>
____ / ____ / _____	<input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Rehabilitation unit public <input type="checkbox"/> Rehabilitation unit private <input type="checkbox"/> Other hospital / ward / speciality department <input type="checkbox"/> Deceased <input type="checkbox"/> Short term care in residential care facility (New Zealand only) <input type="checkbox"/> Other <input type="checkbox"/> Unknown

<b>Date of final discharge from hospital system if known</b>	<b>Discharge destination from hospital system if known</b>
____ / ____ / _____	<input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Deceased <input type="checkbox"/> Other <input type="checkbox"/> Not known

## Follow Up

	<b>30 days (date)</b> ___ / ___ / _____ Note: record date that follow up was completed	<b>120 days (date)</b> ___ / ___ / _____ Note: record date that follow up was completed
<b>Alive at 30 / 120 days</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes  If discharged from hospital, confirm date of final discharge from hospital system  ___ / ___ / _____	<input type="checkbox"/> No <input type="checkbox"/> Yes  If wasn't discharged at 30 day follow up, confirm date of final discharge from hospital system  ___ / ___ / _____
<b>Residential status</b>	<input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Rehabilitation unit public <input type="checkbox"/> Rehabilitation unit private <input type="checkbox"/> Other hospital / ward / speciality department <input type="checkbox"/> Deceased <input type="checkbox"/> Short term care in residential care facility (New Zealand only) <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Rehabilitation unit public <input type="checkbox"/> Rehabilitation unit private <input type="checkbox"/> Other hospital / ward / speciality department <input type="checkbox"/> Deceased <input type="checkbox"/> Short term care in residential care facility (New Zealand only) <input type="checkbox"/> Other <input type="checkbox"/> Unknown
<b>Weight bearing status</b>	<input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Unknown	<input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Unknown
<b>Walking Ability</b>	<input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair or chair/bed bound <input type="checkbox"/> Unknown	<input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair or chair/bed bound <input type="checkbox"/> Unknown
<b>Bone protection</b>	<input type="checkbox"/> no bone protection medication <input type="checkbox"/> yes, calcium and/or vitamin D only <input type="checkbox"/> yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> not known	<input type="checkbox"/> no bone protection medication <input type="checkbox"/> yes, calcium and/or vitamin D only <input type="checkbox"/> yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> not known
<b>Re-operation within 30 / 120 days</b>	<input type="checkbox"/> No reoperation <input type="checkbox"/> Reduction of dislocated prosthesis <input type="checkbox"/> Washout or debridement <input type="checkbox"/> Implant removal <input type="checkbox"/> Revision of internal fixation <input type="checkbox"/> Conversion to Hemiarthroplasty <input type="checkbox"/> Conversion to THR <input type="checkbox"/> Excision arthroplasty <input type="checkbox"/> Revision arthroplasty <input type="checkbox"/> Unknown  Note: Most significant procedure only	<input type="checkbox"/> No reoperation <input type="checkbox"/> Reduction of dislocated prosthesis <input type="checkbox"/> Washout or debridement <input type="checkbox"/> Implant removal <input type="checkbox"/> Revision of internal fixation <input type="checkbox"/> Conversion to Hemiarthroplasty <input type="checkbox"/> Conversion to THR <input type="checkbox"/> Excision arthroplasty <input type="checkbox"/> Revision arthroplasty <input type="checkbox"/> Unknown  Note: Most significant procedure only