

Hospital:

State / Territory: Australia

First Name	Surname	Patient's postcode
Date of Birth (dd/mm/yyyy) ___/___/_____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Contact telephone number
Hospital MRN	Patient type <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Overseas <input type="checkbox"/> Not known	Indigenous Status <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Not known
Medicare number		

Admission via ED of operating hospital <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	If transferred from another hospital Name of transferring hospital: ED/Hospital arrival date/time ___/___/_____ :__hrs (transferring hospital) <small>Record time using 24hr clock</small>	
ED/Hospital Admission (operating hospital) Admission ___/___/_____ :__hrs Departure ___/___/_____ :__hrs (from ED) <small>Record time using 24hr clock</small>	If an in-patient fracture (time using 24hr clock) Date / time of diagnosis ___/___/_____ :__hrs <small>Record time using 24hr clock</small>	
Usual Place of Residence <input type="checkbox"/> Private residence including retirement village <input type="checkbox"/> Residential care facility <input type="checkbox"/> Other <input type="checkbox"/> Not known <small>Note: If holiday residence/respite care, document usual place of residence</small>	Type of ward admitted to <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	
Walking ability pre-admission <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 <input type="checkbox"/> Usually uses a wheel chair/ bed bound <input type="checkbox"/> Not known <small>Note: if a person has different levels of mobility on different surfaces then record the level of most assistance</small>	Preadmission cognitive status <input type="checkbox"/> Normal cognition <input type="checkbox"/> Impaired cognition or known dementia <input type="checkbox"/> Not known or recorded	Preoperative cognitive assessment <input type="checkbox"/> Cognition not assessed <input type="checkbox"/> Cognition assessed and normal <input type="checkbox"/> Cognition assessed and impaired <input type="checkbox"/> Not known <small>Note: cognitive assessment requires use of a validated tool</small>
Pain Assessment <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	Pain Management <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	
Bone protection medication at admission <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) denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known		
Pre-operative medical assessment <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 <small>This is in addition to preoperative anaesthetic and orthopaedic review</small>	Side of fracture <input type="checkbox"/> Left <input type="checkbox"/> Right If bilateral – complete a separate record for each fracture	
Atypical fracture <input type="checkbox"/> Not a pathological or atypical fracture <input type="checkbox"/> Pathological fracture <input type="checkbox"/> Atypical fracture <small>See data dictionary if uncertain of definitions</small>	Type of fracture <input type="checkbox"/> Intracapsular – undisplaced / impacted <input type="checkbox"/> Intracapsular - displaced <input type="checkbox"/> Per / intertrochanteric <input type="checkbox"/> Subtrochanteric <small>Note: Basal/basicervical #s are to be classed as per/intertrochanteric</small>	

Did the patient undergo surgery	Date & time of primary surgery
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ / _____ / _____ ____:____ hrs Record time using 24hr clock
Reason if delay > 48 hours	Anaesthesia
<input type="checkbox"/> No delay - surgery < 48 hrs <input type="checkbox"/> Delayed due to patient deemed medically unfit <input type="checkbox"/> Delayed due to issues with anticoagulation <input type="checkbox"/> Delayed due to theatre availability <input type="checkbox"/> Delayed due to surgeon availability <input type="checkbox"/> 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 of the first hospital or diagnosis of hip fracture for those with a fracture from an in-patient fall	<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
Analgesia (nerve block)	Consultant present during surgery
<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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
Operation Performed	ASA Grade
<input type="checkbox"/> Cannulated screws (e.g. multiple screws) <input type="checkbox"/> Sliding hip screw <input type="checkbox"/> Intramedullary nail – short <input type="checkbox"/> Intramedullary nail – long <input type="checkbox"/> Hemiarthroplasty – stem cemented <input type="checkbox"/> Hemiarthroplasty – stem uncemented <input type="checkbox"/> Total hip replacement – stem cemented <input type="checkbox"/> Total hip replacement – stem uncemented <input type="checkbox"/> Other <input type="checkbox"/> Not known	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> unknown
Postoperative weight bearing status	First day mobilisation
<input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Not known	<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
New Pressure Injury of the Skin	Delirium assessment
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known Note: Grade 2 + above during acute admission	<input type="checkbox"/> Not assessed <input type="checkbox"/> Assessed and not identified <input type="checkbox"/> Assessed and identified <input type="checkbox"/> Not known Note: assessment of delirium requires use of a validated tool
Clinical malnutrition assessment	First day walking
<input type="checkbox"/> Not done <input type="checkbox"/> Malnourished <input type="checkbox"/> Not malnourished <input type="checkbox"/> Not known	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known
Assessed by Geriatrician in acute phase of care	Date initially assessed by Geriatrician
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No geriatric medicine service available <input type="checkbox"/> Not known	_____ / _____ / _____
Specialist falls assessment	Bone protection medication at discharge from operating hospital
<input type="checkbox"/> No <input type="checkbox"/> Performed during admission <input type="checkbox"/> Awaits falls clinic assessment <input type="checkbox"/> Further intervention not appropriate <input type="checkbox"/> Not relevant <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) denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known

Discharge

Date of discharge from acute / orthopaedic ward	Discharge destination from acute / orthopaedic ward
___ / ___ / _____	<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"/> Other <input type="checkbox"/> Not known
Date of final discharge from hospital if known	Discharge destination from hospital if known
___ / ___ / _____	<input type="checkbox"/> Private residence (including retirement village) <input type="checkbox"/> Residential aged care facility <input type="checkbox"/> Deceased <input type="checkbox"/> Other <input type="checkbox"/> Not known

Follow Up 120 days

	120 days
Follow up date	___ / ___ / _____ Note: record date that follow up was completed
Alive at 120 days	<input type="checkbox"/> Yes Confirm date of final discharge from hospital system ___ / ___ / _____ <input type="checkbox"/> No Date of death (if known) ___ / ___ / _____
Residential status	<input type="checkbox"/> Private residence (including unit in retirement village) <input type="checkbox"/> Residential aged 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"/> Other <input type="checkbox"/> Not known
Walking ability	<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 <input type="checkbox"/> Usually uses a wheel chair/ bed bound <input type="checkbox"/> Not known
Bone protection	<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) denosumab or teriparatide (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known
Re-operation within 120 days	<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"/> Not relevant <input type="checkbox"/> Not known Note: Most significant procedure only



Health Questionnaire

English version for Australia

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems with walking around
- I have slight problems with walking around
- I have moderate problems with walking around
- I have severe problems with walking around
- I am unable to walk around

PERSONAL CARE

- I have no problems with washing or dressing myself
- I have slight problems with washing or dressing myself
- I have moderate problems with washing or dressing myself
- I have severe problems with washing or dressing myself
- I am unable to wash or dress myself

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

PAIN / DISCOMFORT

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

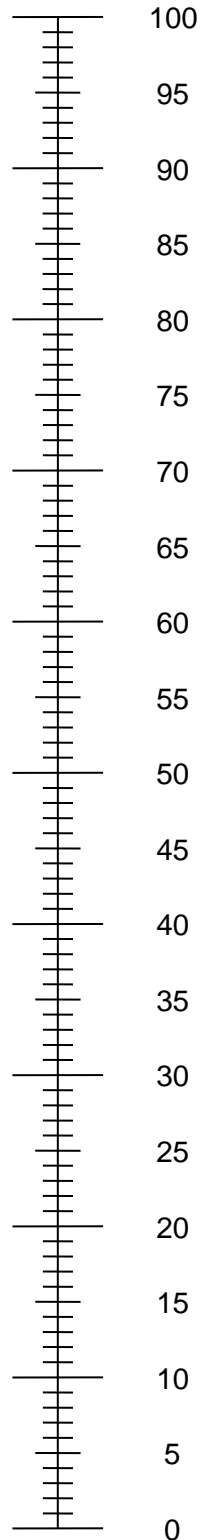
ANXIETY / DEPRESSION

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine