

Hospital

State / Terr / NZ

First Name	Surname	Patient's postcode
_____	_____	_____
Date of Birth	Gender	Ethnic Status
___/___/_____	<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
Hospital Event Number	Contact telephone number	
_____	_____	
National Health Index	Payment status	
_____	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Overseas / other	

Admission via ED of operating hospital	If transferred from another 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	Name of transferring hospital: _____ ED/Hospital arrival date: ___/___/_____ :__hrs Record time using 24hr clock
If admitted via ED	If an in-patient fall (time using 24hr clock)
Admission ___/___/_____ :__hrs Departure ___/___/_____ :__hrs (from ED) Record time using 24hr clock	Date / time of diagnosis ___/___/_____ :__hrs Record time using 24hr clock
Admitted from	Type of ward admitted to
<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

Pain Assessment	Pain Management	
<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	
Walking ability pre-admission	Pre-operative cognitive assessment	Pre-operative cognitive status
<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
Bone protection medication at admission	Pre-operative medical assessment	
<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	
Side of fracture	Type of fracture	
<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	

Atypical fracture	Did the patient undergo surgery
<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

Date & time of primary surgery	ASA grade
___ / ___ / _____ : ___ 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

Reason if delay > 48 hours	Operation Performed
<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

Anaesthesia	Analgesia (nerve block)
<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

Consultant present during surgery	Postoperative weight bearing status
<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

First day mobilisation	New Pressure Injury of the skin
<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

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"/> 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

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"/> Short term care in residential care facility (New Zealand only) <input type="checkbox"/> Other <input type="checkbox"/> Unknown

Date of final discharge from hospital system if known	Discharge destination from hospital system if known
___ / ___ / _____	<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

	30 days (date) ___ / ___ / _____ Note: record date that follow up was completed	120 days (date) ___ / ___ / _____ Note: record date that follow up was completed
Alive at 30 / 120 days	<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 ___ / ___ / _____
Residential status	<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
Weight bearing status	<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
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 (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
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) 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
Re-operation within 30 / 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"/> 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