Hospital:

State / Territory: Australia

ANZHFR
Australian & New Zealand Hip Fracture Registry

First Name	Surname	Patient's postcode
Date of Birth (dd/mm/yyyy)	**Sex**	**Contact telephone number**
__ __/__ __/__ __ __ __	☐ Male ☐ Female ☐ Other	
Hospital MRN	**Patient type**	**Indigenous Status**
	☐ Public ☐ Private ☐ Overseas ☐ Not known	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not known
Medicare number		

Admission via ED of operating hospital	**If transferred from another hospital**
☐ Yes ☐ No, transferred from another hospital ☐ No, in-patient fall ☐ Other/not known	Name of transferring hospital: ED/Hospital arrival date/time __ __ / __ __ / __ __ __ __ __ __:__ __hrs (transferring hospital) Record time using 24hr clock
ED/Hospital Admission (operating hospital)	**If an in-patient fracture (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
Usual Place of Residence	**Type of ward admitted to**
☐ Private residence including retirement village ☐ Residential care facility ☐ Other ☐ Not known Note: If holiday residence/respite care, document usual place of residence	☐ Hip fracture unit /Orthopaedic ward / preferred ward ☐ Outlying ward ☐ HDU / CCU / ICU ☐ Other / not known

Walking ability pre-admission	**Preadmission cognitive status**	**Preoperative cognitive assessment**
☐ Usually walks without walking aids ☐ Usually walks with a stick or crutch ☐ Usually walks with two aids or frame ☐ Usually uses a wheel chair/ bed bound ☐ Not known Note: if a person has different levels of mobility on different surfaces then record the level of most assistance	☐ Normal cognition ☐ Impaired cognition or known dementia ☐ Not known or recorded	☐ Cognition not assessed ☐ Cognition assessed and normal ☐ Cognition assessed and impaired ☐ Not known Note: cognitive assessment requires use of a validated tool

Pain Assessment	**Pain Management**
☐ Documented assessment of pain within 30 minutes of ED presentation ☐ Documented assessment of pain greater than 30 minutes of ED presentation ☐ Pain assessment not documented or not done ☐ Not known or recorded	☐ Analgesia given within 30 minutes of ED presentation ☐ Analgesia given more than 30 minutes after ED presentation ☐ Analgesia provided by paramedics ☐ Analgesia not required ☐ Not known

Bone protection medication at admission

☐ No bone protection medication
☐ Yes, calcium and/or vitamin D only
☐ Yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D)
☐ Not known

Pre-operative medical assessment	**Side of fracture**
☐ No assessment conducted ☐ Geriatrician / geriatric team ☐ Physician / physician team ☐ GP ☐ Specialist nurse ☐ Not known This is in addition to preoperative anaesthetic and orthopaedic review	☐ Left ☐ Right If bilateral – complete a separate record for each fracture
Atypical fracture	**Type of fracture**
☐ Not a pathological or atypical fracture ☐ Pathological fracture ☐ Atypical fracture See data dictionary if uncertain of definitions	☐ Intracapsular – undisplaced / impacted ☐ Intracapsular - displaced ☐ Per / intertrochanteric ☐ Subtrochanteric Note: Basal/basicervical #s are to be classed as per/intertrochanteric

Did the patient undergo surgery	Date & time of primary surgery
□ Yes □ No	__ __ / __ __ / __ __ __ __ __ __:__ __hrs Record time using 24hr clock
Reason if delay > 48 hours	**Anaesthesia**
□ No delay - surgery < 48 hrs □ Delayed due to patient deemed medically unfit □ Delayed due to issues with anticoagulation □ Delayed due to theatre availability □ Delayed due to surgeon availability □ Delayed due to delayed diagnosis of hip fracture □ Other type of delay (state reason) □ 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	□ General anaesthetic □ Spinal / regional anaesthesia □ General and spinal/regional anaesthesia □ Other – state □ Not known
Analgesia (nerve block)	**Consultant present during surgery**
□ Nerve block administered preoperative (before arriving in OT) □ Nerve block administered in OT □ Both □ Neither □ Not known	□ Yes □ No □ Not known
Operation Performed	**ASA Grade**
□ Cannulated screws (e.g. multiple screws) □ Sliding hip screw □ Intramedullary nail – short □ Intramedullary nail – long □ Hemiarthroplasty – stem cemented □ Hemiarthroplasty – stem uncemented □ Total hip replacement – stem cemented □ Total hip replacement – stem uncemented □ Other □ Not known	□ 1 □ 2 □ 3 □ 4 □ 5 □ unknown
Postoperative weight bearing status	**First day mobilisation**
□ Unrestricted weight bearing □ Restricted / non weight bearing □ Not known	□ Patient out of bed and given opportunity to start mobilising day 1 post surgery □ Patient not given opportunity to start mobilising day 1 post surgery □ Not known
New Pressure Injury of the Skin	**Delirium assessment**
□ No □ Yes □ Not known Note: Grade 2 + above during acute admission	□ Not assessed □ Assessed and not identified □ Assessed and identified □ Not known Note: assessment of delirium requires use of a validated tool
Clinical malnutrition assessment	
□ Not done □ Malnourished □ Not malnourished □ Not known	
Assessed by Geriatrician in acute phase of care	**Date initially assessed by Geriatrician**
□ No □ Yes □ No geriatric medicine service available □ Not known	__ __ / __ __ / __ __ __ __
Specialist falls assessment	**Bone protection medication at discharge from operating hospital**
□ No □ Performed during admission □ Awaits falls clinic assessment □ Further intervention not appropriate □ Not relevant □ Not known	□ No bone protection medication □ Yes, calcium and/or vitamin D only □ Yes, bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) □ Not known

Discharge

Date of discharge from acute / orthopaedic ward	Discharge destination from acute / orthopaedic ward
__ __ / __ __ / __ __ __ __	□ Private residence (including retirement village) □ Residential care facility □ Rehabilitation unit - public □ Rehabilitation unit - private □ Other hospital / ward / speciality department □ Deceased □ Other □ Not known
Date of final discharge from hospital if known	**Discharge destination from hospital if known**
__ __ / __ __ / __ __ __ __	□ Private residence (including retirement village) □ Residential aged care facility □ Deceased □ Other □ Not known

Follow Up 120 days

	120 days
Follow up date	__ __ / __ __ / __ __ __ __ Note: record date that follow up was completed
Alive at 120 days	□ No □ Yes Confirm date of final discharge from hospital system __ __ / __ __ / __ __ __ __
Residential status	□ Private residence (including unit in retirement village) □ Residential aged care facility □ Rehabilitation unit - public □ Rehabilitation unit - private □ Other hospital / ward / speciality department □ Deceased □ Other □ Not known
Weight-bearing status	□ Unrestricted weight bearing □ Restricted / non weight bearing □ Not known
Walking ability	□ Usually walks without walking aids □ Usually walks with a stick or crutch □ Usually walks with two aids or frame □ Usually uses a wheel chair/ bed bound □ Not known
Bone protection	□ No bone protection medication □ Yes - Calcium and/or vitamin D only □ Yes - Bisphosphonate (oral or IV) strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) □ Not known
Re-operation within120 days	□ No reoperation □ Reduction of dislocated prosthesis □ Washout or debridement □ Implant removal □ Revision of internal fixation □ Conversion to Hemiarthroplasty □ Conversion to THR □ Excision arthroplasty □ Revision arthroplasty □ Not relevant □ Not known Note: Most significant procedure only