

Hospital:
Country: New Zealand

First Name	Surname		Ethnic Status <input type="checkbox"/> European not further defined <input type="checkbox"/> New Zealand European <input type="checkbox"/> Other European <input type="checkbox"/> Māori <input type="checkbox"/> Pacific peoples not further defined <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Māori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Tokelauan <input type="checkbox"/> Fijian <input type="checkbox"/> Other Pacific Peoples <input type="checkbox"/> Asian not further defined <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Latin American <input type="checkbox"/> African <input type="checkbox"/> Other Ethnicity <input type="checkbox"/> Don't know <input type="checkbox"/> Refused to answer <input type="checkbox"/> Response unidentifiable <input type="checkbox"/> Not stated
Date of Birth (dd/mm/yyyy) ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex or indeterminate <input type="checkbox"/> Not stated / inadequately described		
Hospital Event Number	Patient's postcode	Contact phone 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 <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		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 Note: If holiday residence/respite care, document usual place of residence	
If transferred from another hospital Name of transferring hospital: Transferring hospital arrival date ____/____/____ Transferring hospital arrival time ____:____hrs Record time using 24hr clock		ED/Hospital Admission (operating hospital) Admission ____/____/____ ____:____hrs Departure ____/____/____ ____:____hrs (from ED) Record time using 24hr clock	
If an in-patient fracture (time using 24hr clock) Date of diagnosis ____/____/____ Time of diagnosis: ____:____hrs Record time using 24hr clock		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	
Preadmission 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 Note: if a person has different levels of mobility on different surfaces then record the level of most assistance		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	
Preoperative cognitive assessment <input type="checkbox"/> Not assessed <input type="checkbox"/> Assessed and normal <input type="checkbox"/> Assessed and impaired <input type="checkbox"/> Not known Note: cognitive assessment requires use of a validated tool	Preadmission cognitive status <input type="checkbox"/> Normal cognition <input type="checkbox"/> Impaired cognition or known dementia <input type="checkbox"/> Not known	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 not required – already provided by paramedics <input type="checkbox"/> Analgesia not required – no pain documented on assessment <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		Clinical Frailty Scale – Preinjury Status <input type="checkbox"/> 1 Very fit <input type="checkbox"/> 2 Well <input type="checkbox"/> 3 Well with treated comorbid conditions <input type="checkbox"/> 4 Vulnerable <input type="checkbox"/> 5 Mildly frail <input type="checkbox"/> 6 Moderately frail <input type="checkbox"/> 7 Severely frail <input type="checkbox"/> 8 Very severely frail <input type="checkbox"/> 9 Terminally ill <input type="checkbox"/> Not known	
Preoperative 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 This is in addition to preoperative anaesthetic and orthopaedic review		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 See data dictionary if uncertain of definitions		Type of 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	

Did the patient undergo surgery <input type="checkbox"/> Yes <input type="checkbox"/> No - surgical fixation not clinically indicated <input type="checkbox"/> No - patient for palliation <input type="checkbox"/> No - other reason	Date & time of primary surgery <p style="text-align: center;">___ / ___ / _____ ___:___ hrs</p> <p style="text-align: right;">Record time using 24hr clock</p>
Reason if delay > 48 hours <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 <small>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</small>	ASA Grade <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> unknown
Anaesthesia <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) <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 <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known <small>Note: To record yes, consultant must be scrubbed and operating</small>	Type of operation <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
Postoperative weight bearing status <input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Not known	First day mobilisation <input type="checkbox"/> Patient 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
First day walking <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known	New Pressure Injury of the skin <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known <small>Note: Grade 2 + above during acute admission</small>
Delirium assessment <input type="checkbox"/> Not assessed <input type="checkbox"/> Assessed and not identified <input type="checkbox"/> Assessed and identified <input type="checkbox"/> Not known <small>Note: assessment of delirium requires use of a validated tool</small>	Clinical malnutrition assessment <input type="checkbox"/> Not done <input type="checkbox"/> Malnourished <input type="checkbox"/> Not malnourished <input type="checkbox"/> Not known
Assessed by Geriatrician in acute phase of care <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No geriatric medicine service available <input type="checkbox"/> Not known	Date initially assessed by Geriatrician <p style="text-align: center;">___ / ___ / _____</p>
Specialist falls assessment <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	Bone protection medication at discharge from operating hospital <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

Follow up date	<p style="text-align: center;">120 days</p> ___ / ___ / _____ 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

EQ5D5L (optional)

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

MOBILITY

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems 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

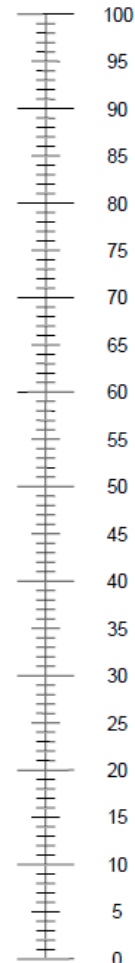
ANXIETY / DEPRESSION

- 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