

Hospital:  
Country: New Zealand

<b>First Name</b>	<b>Surname</b>	<b>Contact phone number</b>	<b>Ethnic Status</b>
			<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
<b>Date of Birth (dd/mm/yyyy)</b>	<b>Gender</b>		
___/___/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex or indeterminate <input type="checkbox"/> Not stated / inadequately described		
<b>Hospital Event Number</b>	<b>Patient's postcode</b>	<b>Email address</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 (via ED) <input type="checkbox"/> No – transferred from another hospital (direct to ward) <input type="checkbox"/> No – in-patient fall <input type="checkbox"/> Other/not known		Name of transferring hospital:  ED/Hospital arrival date/time ___/___/_____ :__ hrs (transferring hospital) <span style="float: right;">Record time using 24hr clock</span>	
<b>ED/Hospital admission (operating hospital)</b>		<b>If an in-patient fracture (time using 24hr clock)</b>	
Admission ___/___/_____ :__ hrs  Departure ___/___/_____ :__ hrs (from ED) <span style="float: right;">Record time using 24hr clock</span>		Date / time of diagnosis ___/___/_____ :__ hrs  <span style="float: right;">Record time using 24hr clock</span>	
<b>Usual place of residence</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		<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>Preadmission walking ability</b>		<b>Transferred patients only: Nerve block before transfer</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 <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		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known	
		<b>Pain Management</b>	
		<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	
<b>Preoperative cognitive assessment</b>	<b>Preadmission cognitive status</b>	<b>Delirium assessment prior to surgery</b>	
<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 e.g. 4AT	<input type="checkbox"/> Normal cognition <input type="checkbox"/> Impaired cognition or known dementia <input type="checkbox"/> Not known	<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 e.g.4AT	
<b>Bone protection medication at admission</b>		<b>Clinical Frailty Scale – Preinjury Status</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) denosumab, romosozumab, teriparatide, raloxifene or HRT (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known		<input type="checkbox"/> 1 Very fit <input type="checkbox"/> 7 Severely frail <input type="checkbox"/> 2 Well <input type="checkbox"/> 8 Very severely frail <input type="checkbox"/> 3 Well with treated comorbid conditions <input type="checkbox"/> 9 Terminally ill <input type="checkbox"/> 4 Vulnerable <input type="checkbox"/> Other validated frailty tool <input type="checkbox"/> 5 Mildly frail <input type="checkbox"/> Not known <input type="checkbox"/> 6 Moderately frail	
<b>Preoperative medical assessment</b>		<b>Side of fracture</b>	
<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		<input type="checkbox"/> Left <input type="checkbox"/> Right  If bilateral – complete a separate record for each fracture	
<b>Atypical fracture</b>		<b>Type of fracture</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"/> 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>Did the patient undergo surgery</b>	<b>Date &amp; time of primary surgery</b>
<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	<p style="text-align: center;">___ / ___ / _____ : ___ hrs</p> <p style="text-align: right;">Record time using 24hr clock</p>
<b>Reason if delay &gt; 36 hours</b>	<b>ASA Grade</b>
<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>	<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>Anaesthesia</b>	<b>Analgesia (nerve block)</b>
<input type="checkbox"/> General anaesthetic <input type="checkbox"/> Spinal anaesthesia <input type="checkbox"/> General and spinal 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>Type of operation</b>
<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>	<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
<b>Postoperative weight bearing status</b>	<b>Clinical malnutrition assessment</b>
<input type="checkbox"/> Unrestricted weight bearing <input type="checkbox"/> Restricted / non weight bearing <input type="checkbox"/> Not known	<input type="checkbox"/> Not done <input type="checkbox"/> Malnourished <input type="checkbox"/> Not malnourished <input type="checkbox"/> Not known
<b>First day walking</b>	<b>New Pressure Injury of the skin</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known  <small>Note: Grade 2 + above during acute admission</small>
<b>Postoperative delirium assessment</b>	<b>Oral nutritional supplements during admission</b>
<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>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known
<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	<p style="text-align: center;">___ / ___ / _____</p>
<b>Specialist falls assessment</b>	<b>Bone protection medication at discharge from hospital</b>
<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, romosozumab, teriparatide, raloxifene or HRT (with or without calcium and/or vitamin D) <input type="checkbox"/> No but received prescription at separation from hospital <input type="checkbox"/> Not known

## Discharge

<b>Date of discharge from acute ward</b>	<b>Discharge destination from acute 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"/> Not known
<b>Date of final discharge from hospital if known</b>	<b>Discharge destination from hospital if known</b>
___ / ___ / _____	<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

<b>Follow up date</b>	<b>120 days</b> ___ / ___ / _____ Note: record date that follow up was completed
<b>Alive at 120 days</b>	<input type="checkbox"/> Yes    Confirm date of final discharge from hospital system    ___ / ___ / _____ <input type="checkbox"/> No      Date of death (if known)    ___ / ___ / _____
<b>Residential status</b>	<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
<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 <input type="checkbox"/> Usually uses a wheel chair/ bed bound <input type="checkbox"/> Not known
<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), denosumab, romosozumab, teriparatide, raloxifene or HRT (with or without calcium and/or vitamin D) <input type="checkbox"/> Not known
<b>Re-operation within 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"/> Not relevant <input type="checkbox"/> Not known Note: Most significant procedure only

EQ5D5L

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

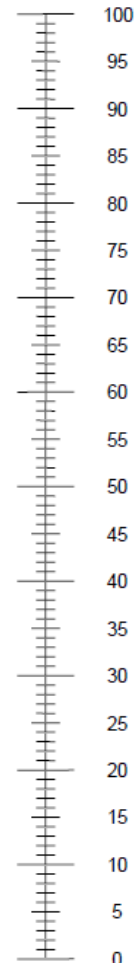
**ANXIETY / DEPRESSION**

- 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