This form is to be filled in by the treating surgeon

FASHION

Site ID: ☐☐ Participant ID: F A S ☐☐☐

Hip Arthroscopy Case Report Form

Patient Initials: ☐☐☐

Date of Birth *(dd/mm/yyyy)*: ☐☐ ☐☐ ☐☐☐☐

Date of Surgery *(dd/mm/yyyy)*: ☐☐ ☐☐ ☐☐☐☐

Key stage undertaken	Please tick to confirm completed	If not completed please give a reason
1. General anaesthetic with muscle relaxation	☐	
2. Supine or lateral patient positioning	☐	
3. Operating table used with facility for traction and range of movement testing	☐	
4. Arthroscopy of central compartment	☐	
5. Arthroscopy of peripheral compartment	☐	
6. Entire acetabular labrum examined	☐	
7. Entire articular surface examined	☐	
8. Confirmed impingement has been relieved using either range of movement testing or an image intensifier.	☐	
9. Did the patient have any intraoperative complications e.g. fracture, iatrogenic cartilage damage, anaesthetic problems?	☐	Please specify the complication(s) and solution:-

10. Did you prescribe your standard post-operative rehabilitation/physiotherapy for this patient?

Yes ☐ No ☐

If No, please provide a brief description of your post-operative rehabilitation prescription below.

11.	Attach an anonymised copy of the operative note to this CRF. NB: Note the Participant ID on the copy	☐
12.	Attach at least two intraoperative photo's to show the initial pathology and subsequent surgical solution.	☐

Signed:_____ Date *(dd/mm/yyyy)*: ☐☐ ☐☐ ☐☐☐☐

Print Name:_____

Site ID: ☐☐ Participant ID: F A S ☐☐☐

Post-op MRI

Complete for all patients who have undergone Arthroscopic Surgery.

Date of Post-op MRI Image: ☐☐ ☐☐ ☐☐☐☐

Date Post-op MRI image uploaded to Clinical Graphics BV: ☐☐ ☐☐ ☐☐☐☐

Name of Person uploading image: .....

Signed: ..... Date *(dd/mm/yyyy)*: ☐☐ ☐☐ ☐☐☐☐

Print Name: .....

To be completed by the Research Associate/Nurse

FASHION

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Surgery - 6 Week Complications

In the past 6 weeks has the patient experienced or been treated for any of the following events?

1. Numbness in the groin leg or foot? Yes ☐ No ☐

   If yes, please give details: .....

   .....

2. Wound infection? Yes ☐ No ☐

   Was the wound i) Deep ☐ ii) Superficial ☐

   Was a course of antibiotics prescribed? Yes ☐ No ☐

   Was further surgery required? Yes ☐ No ☐

3. Hip fracture (break) Yes ☐ No ☐

   If yes, please give details: .....

   .....

4. Further surgery because of your hip impingement? Yes ☐ No ☐

   If yes, please give details: .....

   .....

5. Problems with pain medications for your hip impingement? Yes No

   If yes, please give details: .....

   .....

6. Problems with hip joint injections Yes ☐ No ☐

   If yes, please give details: .....

   .....

7. Muscle soreness from exercises that you have been undertaking? Yes ☐ No ☐

   If yes, please give details: .....

   .....

8. A regional pain syndrome? Yes ☐ No ☐

   If yes, please give details: .....

   .....

To be completed by the Research Associate/Nurse

9. Deep Vein Thrombosis (DVT)? Yes ☐ No ☐

If yes, did you see the DVT nurse? Yes ☐ No ☐

If yes, were you prescribed medication? Yes ☐ No ☐

10. Any other complications? Yes ☐ No ☐

If yes, please give details: .....

.....

11. Have you had any other unscheduled appointment at hospital because of your hip impingement? Yes ☐ No ☐

If yes, please give details: .....

.....

Research Associate/Research Nurse Name: .....

Research Associate/Research Nurse Signature : .....

Date: ☐☐ ☐☐ ☐☐☐☐

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