Draft

VERSO SHOULDER HISTORICAL & OPERATIVE FORM

HOSP NO: ☐☐☐☐☐☐☐☐☐

Shade Circles Like This--> ●

STUDY NO: ☐☐☐☐

HOSPITAL: ☐☐☐☐☐☐☐☐☐☐☐☐

Gender: ○ Male ○ Female

Side: ○ Left ○ Right

SURGEON: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of Surgery: ☐☐ / ☐☐ / ☐☐☐☐
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DIAGNOSIS:
○ ROTATOR CUFF ARTHROPATHY ○ RA ○ POST TRAUMATIC ARTHROPATHY
○ REVISION OF SURFACE REPLACEMENT ○ REVISION OF STEMMED PROSTHESIS
○ FAILED ROTATOR CUFF REPAIR ○ NON-UNION ○ REVISION OF REVERSED PROTHESIS
○ OTHER (PLEASE SPECIFY) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

WHICH PROCEDURE WAS PERFORMED? ○ Reversed total shoulder replacement ○ Hemi arthoplasty

HUMERAL SHELL:
○ Small ○ Medium ○ Large
○ Extra large

STEMMED HUMERAL SHELL :
○ 6 mm ○ 8 mm ○ 10 mm
○ 12 mm

MEGA HUMERAL HEAD:
○ 2/3 sphere ○ Hemisphere

LINER: **Diameter:** ○ 36 mm ○ 41 mm
Standard: ○ +3 mm ○ +6 mm ○ +9 mm ○ +12 mm
Retentive: ○ +3 mm ○ +6 mm ○ +9 mm ○ +12 mm

GLENOID HEAD DIAMETER: ○ 36 mm ○ 41 mm

GLENOID LOW PROFILE SCREWS:
Please specify the numbers of screws have been used
○ 15 mm ☐ ○ 20 mm ☐ ○ 25 mm ☐
○ 30 mm ☐ ○ 35 mm ☐
○ 40 mm ☐ ○ 45 mm ☐ ○ 50 mm ☐

SURGICAL APPROACH

○ ANTERO-SUPERIOR (RECOMMENDED)
○ DELTOPECTORAL
○ OTHER (PLEASE SPECIFY BELOW) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

RANGE OF MOTION ON TABLE: (passive movement post replacement)

FORWARD ELEVATION: ☐☐☐ °
EXTERNAL ROTATION: ☐☐☐ °
INTERNAL ROTATION: ☐☐☐ °
TO OPPOSITE AXILLA? ○ YES ○ NO
TO HAIR / HEAD? ○ YES ○ NO

OTHER PROCEDURES PERFORMED

○ Acromioplasty ○ Excision lateral end clavicle ○ Impaction bone graft to the humeral side
○ Impaction bone graft to the glenoid side ○ Use of bone graft substitute ○ Biceps tenodesis
○ Lesser tuberosity osteotomy ○ Clavicular osteotomy ○ Other (Please specify below)
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GLENOID BASEPLATE INITIAL FIXATION: ○ Solid ○ Good/Minimally mobile ○ Loose
HUMERAL SHELL INITIAL FIXATION: ○ Solid ○ Good/Minimally mobile ○ Loose
COMPONENT STABILITY: ○ Stable ○ Mild Instability ○ Unstable

STATE OF ROTATOR CUFF: ○ Absent cuff ○ Massive tear ○ Supraspinatus tear ○ Subscapularis tear ○ Infraspinatus tear ○ Teres minor tear

ROTATOR CUFF REPAIRED? ○ YES ○ NO

Signature _____

DATE: ☐☐ / ☐☐ / ☐☐☐☐
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PLEASE PLACE ALL IMPLANT LABELS ON THE REVERSE OF THIS FORM