Please complete all relevant sections and save the document using the patient name and hospital number as the filename before emailing to nuth.arthroplastymdt@nhs.net Please ensure that all relevant imaging is available for review

MDT Members Present MDT Date Date
For completion at time of MDT.

Patient Details
First Name - Name
Surname - Surname
Date of Birth - Date of Birth
Hospital Number - MRN or NHS.
Age age.

Referral Details
Clinician - Choose an item.
Centre - Choose an item.
Urgency - Choose an item.

Extended MDT Specialists
Microbiology [ ]
Plastics [ ]
Vascular [ ]
Other. Other members required.

**Surgical History**

Primary [ ]  Revision [ ]

Laterality Choose a side.

Joint Joint for discussion

Summary of surgical history implants, complications previous returns to theatre soft tissue concerns.

**Current Concerns and Patients Preferences**

Summary of Clinical Concerns and Patient preferences.

**Comorbidities / Relevant Medical History**

Drug Allergies. Drug allergies.
BMI Weight or BMI
Smoker Choose an item.
Ambulation Choose an item.
Independence Choose an item.Comorbidities
Summary of patient comorbidities.

**Investigations**

Bloods tests
CRP Value
FBC Value
WCC Value.
Other Other relevant bloodImaging
CT. MRI Other imaging.Other
For example Culture Results.

**MDT Outcome**

Summary of the outcome from MDT discussion .

Implant and instrument Requirements

Please indicate kit requirements.

Identified Reason for Revision (if applicable select all that apply)

Infection [ ]
Peri-prosthetic Fracture [ ]
Dislocation [ ]
Wear [ ]
Aseptic loosening [ ]
Implant Fracture [ ]
Component Mismatch [ ]

Lysis [ ]
Stiffness [ ]
Instability [ ]
Extensor Mechanism Dys [ ]
Patella [ ]
Malalignment [ ]
Adverse soft tissue reaction [ ]

Other
Reason for revision