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](mailto: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