Patient Registration Form :

Title: Mr Mrs Miss Ms Dr Master Other: _____

Given Names: _____ **Surname:** _____

Date of Birth: _____

Phone: (H) _____ **(W)** _____ **(M)** _____

Email:_____

Street Address:_____

County :_____ **Post Code:** _____

Postal/Billing Address (If Diifferent**):** _____

Parents Name(if child) _____

Fees paid by: SELF/ WORKERS COMP/ OTHER: _____

Family Doctor: _____

Address: _____

Referring Doctor: _____

Address: _____

Physiotherapist: _____

Address: _____

Patient Occupation: _____

Private Insurance: _____ **Number**_____

Has another Orthopaedic opinion been sought? Please tick. YES NO

Permission to Collect and Store Information:

I have read the above and agree to the collection and storage of information. I authorize Mr. _____to release medical information to the Referring Doctor/ Insurance Company/ Solicitor or the other persons nominated by me.

SIGNED:_____DATE: _____

Hip Arthritis Assessment Form (Patient to Complete)
Mr.Mihai Vioreanu

NAME:
DOB:

1. Date of Consultation: _____

2. Which is your worse hip (circle) **Left** **Right**

3. How long has your hip been bothering you?_____

4. If applicable, what hip problems, injuries or surgeries have you had in the past?
_____
_____

5. What is the main problem with your hip? _____
_____

6. Have you been troubled with pain in your hip in bed at night (circle)?
Never / Occasionally / Most nights / Every night

7. What treatment have you had for your hip to date?_____
_____

8. Are your symptoms (circle): improving / worsening / unchanged ?

9. Do you feel those symptoms are affecting your Quality of Life to the extent that you would like to do something about it? YES / NO.

10. Do you have any back problems or previous back surgery? (please describe)
_____
_____

11. Do you feel the affected limb is shorter / longer / the same length as the opposite leg.

12. What activities do you wish to return to following your treatment? _____
_____

13. What are your expectations from today's consultation with Mr. Vioreanu?
_____
_____

14. Please enter your: Height _____(kg) & Weight _____(cm)

Harris Hip Score (patient to complete)

Please answer the following questions.

Pain

- ☐ None, or ignores it
- ☐ Slight, occasional, no compromise in activity
- ☐ Mild pain, no effect on average activities, rarely moderate pain with unusual activity, may take aspirin
- ☐ Moderate pain, tolerable but makes concessions to pain. Some limitations of ordinary activity or work. May require occasional pain medication stronger than aspirin
- ☐ Marked pain, serious limitation of activities
- ☐ Totally disabled, crippled, pain in bed, bedridden

Support

- ☐ None
- ☐ Cane/Walking stick for long walks
- ☐ Cane/Walking stick most of the time
- ☐ One crutch
- ☐ Two Canes/Walking sticks
- ☐ Two crutches or not able to walk

Distance walked

- ☐ Unlimited
- ☐ Six blocks (30 minutes)
- ☐ Two or three blocks (10 - 15 minutes)
- ☐ Indoors only
- ☐ Bed and chair only

Limp

- ☐ None
- ☐ Slight
- ☐ Moderate
- ☐ Severe or unable to walk

Activities - shoes, socks

- ☐ With ease
- ☐ With difficulty
- ☐ Unable to fit or tie

Stairs

- ☐ Normally without using a railing
- ☐ Normally using a railing
- ☐ In any manner
- ☐ Unable to do stairs

Public transportation

- ☐ Able to use transportation (bus)
- ☐ Unable to use public transportation (bus)

Sitting

- ☐ Comfortably, ordinary chair for one hour
- ☐ On a high chair for 30 minutes
- ☐ Unable to sit comfortably on any chair

PATIENT INFORMATION STATEMENT AND CONSENT FORM – please read, sign and return

INTRODUCTION

As a patient of M r . V i o r e a n u you are being invited to participate in an information database for patients that have undergone orthopaedic surgery. A database is an electronic collection of information that is stored on a computer.

The purpose of this statement is to inform you of the ways in which your health information is handled and to seek your consent to do this. Before you can decide whether or not to take part in this database, we would like to explain its purpose, how it may help you, any risks to you, and what is expected of you.

YOUR PARTICIPATION IS VOLUNTARY

This statement gives you information about the type of information collected on the database and the possibility that, with your consent, some of the information collected may be used for research purposes. The information that could be extracted from the database and used for research would be de-identified.
Before you learn about the database, it is important that you know the following:

- Your participation is voluntary

- You may decide not to take part or to withdraw your consent at any time from having your health information used for research purposes without losing the benefits of your routine medical care under Mr. Vioreanu

WAYS IN WHICH HEALTH INFORMATION IS COLLECTED

All patients seen by Mr. Vioreanu have a set of medical records that are kept to accurately collect your health information. These records are private, and are only accessed by your treating surgeon and members of his team who are directly involved with your medical care. These private records are the only format in which your health information will be stored.

The information that would be collected includes (for example):

Your name and contact details
Your date of birth
Details of any pathology report and tests related to your surgery
Details of your surgery
Details of your medical history including family history
Information about your outcome after surgery

WHAT IS THE PURPOSE OF THIS DATABASE?

The primary purpose of handling your health information in the way described above is to accurately collect information about your ongoing patient care and outcomes from your surgery.

The secondary purpose of handling your health information in the way described above is:

Identify people who might be eligible for participation in future clinical research/trials

Quality Assurance: this means systematically monitoring the types of treatment and the results of the treatment that our patients receive. This is to ensure that you and other patients having orthopaedic surgery are receiving the best and most current standard of care

Medical Research: your information may be used for medical research. In some cases, if additional data is needed then you may be contacted.

WHAT MEASURES ARE IN PLACE TO PROTECT THE CONFIDENTIALITY OF MY HEALTH INFORMATION?

Files are stored in a secure orthopaedic practice. Data is stored on a single database accessible from two personal computers located at the medical practice which are password protected and only accessible by employees of Mr. Vioreanu.

Any information that is obtained in connection with this database and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing this document, we may discuss/publish the results of data collected on patients and publish in medical journals. In any publication, information will be provided in such a way that you cannot be identified.

BENEFITS

Storing health information in this way is expected to provide direct and indirect benefits to current and future orthopaedic practice.

ALTERNATIVES TO PARTICIPATION

Before you decide to take part in this research, your doctor will talk with you about the other options that are available to you. Possible options will include not consenting to be in the research outlined in section 4.

COSTS

There are no costs to you for allowing us to store your health information as described above. Financial support to cover the costs of maintaining this database is being provided by Mr. Vioreanu.

SPORTS SURGERY CLINIC / TRINITY COLLEGE DUBLIN

I,.....of .....

aged ..... years, agree to participate in the health information collection described in the attached form.

I acknowledge that I have read the patient information statement, which explains why I have been selected, the aims of this health information collection and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

I understand that I can withdraw from the research at any time without prejudice to my relationship with Mr. Vioreanu.

I agree that research data gathered from the results of the research may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact Mr. Vioreanu, or one of their researchers, on (02) 94375999/Fax (02) 94379595 who will be happy to answer them.

I acknowledge receipt of a signed copy of this Consent Form and the Subject Information Statement.

Signature of participant	Please PRINT name	Date
Signature of Investigator(s)	Please PRINT name	Date
Signature of witness	Please PRINT name	Date

ONLY COMPLETE IF YOU DO NOT WISH TO PARTICIPATE:
REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with Mr. Vioreanu.

Signature	Date

Please PRINT Name

The section for Revocation of Consent should be forwarded to:

Mr. Mihai Vioreanu, MD, FRCSI
Sports Surgery Clinic
Suite 17 , Santry Demense
Santru, Dublin 9
Ireland.