

PERI-OPERATIVE FORM-2

(Please Print)

Surgeon (primary):		Hospital:		Hospital medical number: (URL)	
Patient's last name:		First:	Middle:		

Instructions:

Surgeons are responsible for ensuring all the required information on this form is as complete and accurate as possible. The completed form should be forwarded to the State Coordinator, who must check for any omissions prior to sending the form to the EVAR Project Data Manager:

Data Manager, EVAR Project
Basil Hetzel Institute
28 Woodville Road
DX465702
Woodville South, SA 5011
T: 61 8 8133 4015
F. 61 8 8222 7872
E: evartrial@adelaide.edu.au

- On receipt of this form in Adelaide, the Data Manager will add the same de-identifying code previously allocated to this patient. The code must be added to each page of the form (top right hand corner).
- This page, where patient name and address are provided, will be physically separated from the rest of the form and stored separately to the EVAR data.
- For the duration of the research project only the Data Manager and Principal Investigator are permitted to re-identify patient forms, and only where this is necessary for obtaining follow-up information or for quality assurance purposes.

PERI-OPERATIVE & DISCHARGE FORM

(Please Print)

Date of admission: / /		Date of Procedure: / /		Date of Discharge: / /		
OPERATIVE INFORMATION						
Device type:	Aorto-aortic tube <input type="checkbox"/>	Aorto-bi-iliac bifurcated <input type="checkbox"/>	Aorto-uni-iliac + crossover <input type="checkbox"/>	Fenestrated <input type="checkbox"/>		
Name of device & manufacturer:	Zenith (Cook) <input type="checkbox"/>	Endurant (Medtronic) <input type="checkbox"/>	Excluder (Gore) <input type="checkbox"/>			
	Anaconda (Vascutek) <input type="checkbox"/>	Other <input type="checkbox"/> Specify:				
Planned additional procedures: Yes <input type="checkbox"/> No <input type="checkbox"/>						
Internal iliac embolisation and graft to external iliac artery:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Laterality: Left <input type="checkbox"/> Right <input type="checkbox"/>			
Iliac branch graft:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Laterality: Left <input type="checkbox"/> Right <input type="checkbox"/>			
Inferior mesenteric artery embolisation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Iliofemoral graft or crossover:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Proximal fenestration(s):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of vessels:			
Vessels involved:	Left renal artery <input type="checkbox"/>	Right renal artery <input type="checkbox"/>	SMA <input type="checkbox"/>	Coeliac artery <input type="checkbox"/>		
Other planned procedure(s):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Unplanned additional procedures: Yes <input type="checkbox"/> No <input type="checkbox"/>						
Stent / extension graft to proximal neck:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Stent to body or distal end of graft:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Extension to external iliac +/- embolisation of internal iliac artery:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Conversion to open repair:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Other unplanned procedure(s):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Successful exclusion of aneurysm	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Patient status: Alive <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death:				
Date of death	/ /					
OPERATIVE COMPLICATIONS						
Operative complication(s):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Vessel complications:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Misplaced deployment:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Failed deployment:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Distal embolisation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Failed access:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
Twist/kink/obstruction:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:			
GRAFT COMPLICATIONS						
Endoleak:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type I <input type="checkbox"/>	Type II <input type="checkbox"/>	Type III <input type="checkbox"/>	Type IV <input type="checkbox"/>
Endotension:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Migration:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Distance (mm):			

Graft infection:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Graft thrombosis:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other graft complication:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:
Reoperation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date of reoperation: / /
Cause of reoperation:			
Bleeding:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Endoleak:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Rupture:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other cause:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:

SYSTEMIC COMPLICATIONS

Cardiac:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cerebral:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pulmonary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Renal:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hepatobiliary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bowel:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sepsis:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:

ACCESS SITE & LOWER LIMB COMPLICATIONS

Bleeding, haematoma, false aneurysm:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Arterial thrombosis:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Peripheral emboli:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Limb loss:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe:

COMMENTS: