

|                                                                                                                                                                                                                                                   |                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| <div style="font-size: 48px; font-weight: bold; color: orange; margin-bottom: 10px;">S1</div> <div style="font-size: 36px; font-weight: bold; margin-bottom: 10px;">Shoulder</div> <div style="font-size: 36px; font-weight: bold;">Primary</div> | <p><b>Patient addressograph</b></p> |
| <p><b>Important:</b><br/>Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Data Set form component labels sheet'. Please ensure that all sheets are stapled together.</p>                         |                                     |

**All fields are mandatory unless otherwise indicated**

|                                                                                  |                 |
|----------------------------------------------------------------------------------|-----------------|
| <b>Remember! Make a note of the NJR reference number when you enter the data</b> | <b>NJR ref:</b> |
|----------------------------------------------------------------------------------|-----------------|

**Patient details**

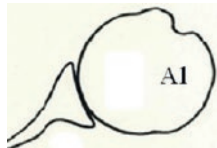
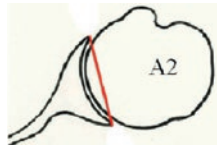
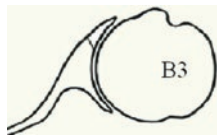
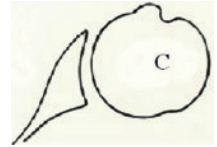
|                                                                                                                        |                                 |                                       |                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NJR patient consent obtained                                                                                           | Yes <input type="checkbox"/>    | No <input type="checkbox"/>           | Not recorded <input type="checkbox"/>                                                                                                                                                                                                                                            |
| If 'Yes' or 'No' was selected for patient consent above, was consent provided by a consultee on behalf of the patient? | Yes <input type="checkbox"/>    | No/Not known <input type="checkbox"/> | This refers to NJR consent being provided by a third party on behalf of the patient, not the 'consent to operate' normally obtained by the consultant. If an 'NJR Patient Consultee Declaration Form' has not been completed, this section should be completed as 'No/Not known' |
| Has the patient consented to linkage of study data to NJR data?                                                        | Yes <input type="checkbox"/>    | No/Not known <input type="checkbox"/> | Study ID (max 25 characters)                                                                                                                                                                                                                                                     |
| Body Mass Index (enter either H&W <b>or</b> BMI <b>or</b> tick Not available box)                                      | Height (In M)<br>Weight (In KG) |                                       | BMI                                                                                                                                                                                                                                                                              |
|                                                                                                                        |                                 |                                       | Not available <input type="checkbox"/>                                                                                                                                                                                                                                           |
| Handedness                                                                                                             | Left <input type="checkbox"/>   | Right <input type="checkbox"/>        | Ambidextrous <input type="checkbox"/>                                                                                                                                                                                                                                            |
|                                                                                                                        |                                 |                                       | Unknown <input type="checkbox"/>                                                                                                                                                                                                                                                 |

**Patient identifiers**

|                                                                 |                                                                                                      |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Forename(s)                                                     |                                                                                                      |
| Surname                                                         |                                                                                                      |
| Sex                                                             | Male <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate <input type="checkbox"/> |
| Date of birth (DD/MM/YYYY)                                      |                                                                                                      |
| Patient postcode                                                | Overseas address <input type="checkbox"/>                                                            |
| NHS number <b>or</b> National Patient Identifier (if available) |                                                                                                      |
| Patient hospital ID                                             |                                                                                                      |
| Patient email address (if provided)                             |                                                                                                      |
| Patient mobile phone number (if provided)                       |                                                                                                      |

**Operation details**

|                             |                              |                                      |                            |                            |                            |
|-----------------------------|------------------------------|--------------------------------------|----------------------------|----------------------------|----------------------------|
| Hospital                    |                              |                                      |                            |                            |                            |
| Operation date (DD/MM/YYYY) |                              |                                      |                            |                            |                            |
| Anaesthetic types           | General                      | <input type="checkbox"/>             | Regional – nerve block     | <input type="checkbox"/>   |                            |
| Patient ASA grade           | 1 <input type="checkbox"/>   | 2 <input type="checkbox"/>           | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| Operation funding           | NHS <input type="checkbox"/> | Independent <input type="checkbox"/> |                            |                            |                            |

| Surgeon details                                                |  |                                                                                                                                                            |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
|----------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------|--|--|--|
| Consultant in charge                                           |  |                                                                                                                                                            |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
| Operating surgeon number one                                   |  |                                                                                                                                                            |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
| Operating surgeon number one Grade                             |  | Consultant <input type="checkbox"/>                                                                                                                        | SPR/ST3-8 <input type="checkbox"/> | Senior Fellow (Post-CCT or equivalent) <input type="checkbox"/> | F1-ST2 <input type="checkbox"/>                                                       | Specialty doctor/SAS <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |
| Dual consultant operation?                                     |  | Yes <input type="checkbox"/>                                                                                                                               |                                    | No <input type="checkbox"/>                                     |                                                                                       |                                               |                                |  |  |  |
| Operating consultant number two (if dual consultant operation) |  |                                                                                                                                                            |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
| First assistant Grade                                          |  | Consultant <input type="checkbox"/>                                                                                                                        |                                    | Other <input type="checkbox"/>                                  |                                                                                       |                                               |                                |  |  |  |
| Shoulder primary procedure details                             |  |                                                                                                                                                            |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
| Side                                                           |  | Left <input type="checkbox"/>                                                                                                                              |                                    | Right <input type="checkbox"/>                                  |                                                                                       |                                               |                                |  |  |  |
| Indications for implantation<br>(select all that apply)        |  | Osteoarthritis                                                                                                                                             |                                    | <input type="checkbox"/>                                        | Metastatic cancer/malignancy                                                          |                                               | <input type="checkbox"/>       |  |  |  |
|                                                                |  | Avascular necrosis (AVN)                                                                                                                                   |                                    | <input type="checkbox"/>                                        | Dislocation arthropathy                                                               |                                               | <input type="checkbox"/>       |  |  |  |
|                                                                |  | Cuff tear arthropathy                                                                                                                                      |                                    | <input type="checkbox"/>                                        | Infection – previous                                                                  |                                               | <input type="checkbox"/>       |  |  |  |
|                                                                |  | Cuff tear without arthropathy                                                                                                                              |                                    | <input type="checkbox"/>                                        | Infection – active                                                                    |                                               | <input type="checkbox"/>       |  |  |  |
|                                                                |  | Inflammatory arthropathy                                                                                                                                   |                                    | <input type="checkbox"/>                                        | Other                                                                                 |                                               | <input type="checkbox"/>       |  |  |  |
|                                                                |  | Trauma                                                                                                                                                     |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
|                                                                |  | Trauma acute                                                                                                                                               |                                    | <input type="checkbox"/>                                        |                                                                                       |                                               |                                |  |  |  |
|                                                                |  | Trauma chronic                                                                                                                                             |                                    | <input type="checkbox"/>                                        |                                                                                       |                                               |                                |  |  |  |
| Shoulder glenoid morphology                                    |  | Radiograph type (select all that apply)                                                                                                                    |                                    |                                                                 | CT <input type="checkbox"/>                                                           | MRI <input type="checkbox"/>                  | X-ray <input type="checkbox"/> |  |  |  |
|                                                                |  | Modified Walch (for concentric, posterior and anterior) - (select only one)                                                                                |                                    |                                                                 |                                                                                       |                                               |                                |  |  |  |
|                                                                |  | Centred humeral head, minor erosion                                                                                                                        |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |
|                                                                |  | Centred humeral head, major central glenoid erosion. A line drawn from the anterior to the posterior rim of the native glenoid transects the humeral head. |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |
|                                                                |  | Posterior subluxated head, no bony erosion                                                                                                                 |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |
|                                                                |  | Posterior subluxated head, posterior erosion with biconcavity of the glenoid                                                                               |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |
|                                                                |  | Monoconcave and posteriorly worn, with at least 15° of retroversion or at least 70% posterior humeral head subluxation, or both.                           |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |
|                                                                |  | Dysplastic glenoid with at least 25° of retroversion not caused by erosion                                                                                 |                                    | <input type="checkbox"/>                                        |  |                                               |                                |  |  |  |

|                                                                |                                                                                                              |                             |                                             |                                                                                    |                                         |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------|
|                                                                | Any level of glenoid anteversion /anterior defect or with humeral head anterior subluxation of less than 40% |                             | <input type="checkbox"/>                    |  |                                         |
| <b>Superior wear (select if any superior wear)</b>             |                                                                                                              |                             |                                             |                                                                                    |                                         |
|                                                                | Any level of superior wear/superior defect                                                                   |                             | Yes <input type="checkbox"/>                | No <input type="checkbox"/>                                                        |                                         |
| Previous surgery (not arthroplasty)<br>(Select all that apply) | None                                                                                                         | <input type="checkbox"/>    | For cuff tear                               | <input type="checkbox"/>                                                           |                                         |
|                                                                | For fracture                                                                                                 | <input type="checkbox"/>    | For gleno-humeral arthritis                 | <input type="checkbox"/>                                                           |                                         |
|                                                                | For instability                                                                                              | <input type="checkbox"/>    | Previous arthrodesis                        | <input type="checkbox"/>                                                           |                                         |
|                                                                | For impingement                                                                                              | <input type="checkbox"/>    | Other                                       | <input type="checkbox"/>                                                           |                                         |
| <b>Surgical approach</b>                                       |                                                                                                              |                             |                                             |                                                                                    |                                         |
| Patient procedure                                              | Resurfacing total arthroplasty                                                                               | <input type="checkbox"/>    | Stemmed conventional total arthroplasty     | <input type="checkbox"/>                                                           |                                         |
|                                                                | Resurfacing hemiarthroplasty                                                                                 | <input type="checkbox"/>    | Stemmed hemiarthroplasty                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Stemless conventional total arthroplasty                                                                     | <input type="checkbox"/>    | Stemmed total reverse arthroplasty          | <input type="checkbox"/>                                                           |                                         |
|                                                                | Stemless hemiarthroplasty                                                                                    | <input type="checkbox"/>    | Interpositional arthroplasty (glenohumeral) | <input type="checkbox"/>                                                           |                                         |
|                                                                | Stemless total reverse arthroplasty                                                                          | <input type="checkbox"/>    | Planned incomplete primary procedure        | <input type="checkbox"/>                                                           |                                         |
| Fixation humerus                                               | Uncemented <input type="checkbox"/>                                                                          |                             | Cemented <input type="checkbox"/>           | Not applicable <input type="checkbox"/>                                            |                                         |
| Fixation glenoid                                               | Uncemented <input type="checkbox"/>                                                                          |                             | Cemented <input type="checkbox"/>           | Hybrid <input type="checkbox"/>                                                    | Not applicable <input type="checkbox"/> |
| Approach                                                       | Delto-Pectoral <input type="checkbox"/>                                                                      |                             | Trans-deltoid <input type="checkbox"/>      | Other <input type="checkbox"/>                                                     |                                         |
| Patient specific instruments?                                  | Yes <input type="checkbox"/>                                                                                 | No <input type="checkbox"/> |                                             |                                                                                    |                                         |
| Computer guided surgery used?                                  | Yes <input type="checkbox"/>                                                                                 | No <input type="checkbox"/> |                                             |                                                                                    |                                         |
| Biological resurfacing (glenoid)<br>(select all that apply)    | None                                                                                                         | <input type="checkbox"/>    | Reaming                                     | <input type="checkbox"/>                                                           |                                         |
|                                                                | Microfracture                                                                                                | <input type="checkbox"/>    | Interposition                               | <input type="checkbox"/>                                                           |                                         |
| <b>Thromboprophylaxis regime (intention to treat)</b>          |                                                                                                              |                             |                                             |                                                                                    |                                         |
| Chemical                                                       |                                                                                                              |                             | In hospital                                 | At home                                                                            |                                         |
|                                                                | Aspirin                                                                                                      |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | LMWH                                                                                                         |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Pentasaccharide (e.g. Fondaparinux)                                                                          |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Warfarin                                                                                                     |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Direct thrombin inhibitor (e.g. Dabigatran)                                                                  |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Factor Xa inhibitor (e.g. Rivaroxaban/Apixaban)                                                              |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | Other                                                                                                        |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
|                                                                | None                                                                                                         |                             | <input type="checkbox"/>                    | <input type="checkbox"/>                                                           |                                         |
| Mechanical                                                     | Foot pump                                                                                                    | <input type="checkbox"/>    | Other                                       | <input type="checkbox"/>                                                           |                                         |
|                                                                | Intermittent calf compression                                                                                | <input type="checkbox"/>    | None                                        | <input type="checkbox"/>                                                           |                                         |
|                                                                | TED stockings                                                                                                | <input type="checkbox"/>    |                                             |                                                                                    |                                         |

| Bone graft used                                                                                 |                  |                          |                        |                          |             |                          |       |                          |
|-------------------------------------------------------------------------------------------------|------------------|--------------------------|------------------------|--------------------------|-------------|--------------------------|-------|--------------------------|
| Was humeral bone graft used?                                                                    | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Humeral – form                                                                                  | Structural       | <input type="checkbox"/> | Morsellised/chips      | <input type="checkbox"/> |             |                          |       |                          |
| Humeral – type                                                                                  | Autograft        | <input type="checkbox"/> | Allograft              | <input type="checkbox"/> | Synthetic   | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Was glenoid bone graft used?                                                                    | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Glenoid – form                                                                                  | Structural       | <input type="checkbox"/> | Morsellised/chips      | <input type="checkbox"/> |             |                          |       |                          |
| Glenoid – type                                                                                  | Autograft        | <input type="checkbox"/> | Allograft              | <input type="checkbox"/> | Synthetic   | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Structural implant or other augment(s) used e.g. augment, spacer, block, wedge, collar, segment |                  |                          |                        |                          |             |                          |       |                          |
| Were humeral structural implant or other augment(s) used?                                       | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Were glenoid structural implant or other augment(s) used?                                       | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| If yes, please affix implant labels under “Accessories”                                         |                  |                          |                        |                          |             |                          |       |                          |
| Rotator cuff                                                                                    |                  |                          |                        |                          |             |                          |       |                          |
| Rotator cuff condition                                                                          | Normal           | <input type="checkbox"/> | Attenuated             | <input type="checkbox"/> | Absent/torn | <input type="checkbox"/> |       |                          |
| Rotator cuff repaired?                                                                          | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Repair type                                                                                     | Primary repair   | <input type="checkbox"/> | Augmented patch repair | <input type="checkbox"/> |             |                          |       |                          |
| Other soft tissues                                                                              |                  |                          |                        |                          |             |                          |       |                          |
| Long head biceps (LHB) present?                                                                 | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| LHB tenotomy performed?                                                                         | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| LHB tenodesis performed?                                                                        | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Muscle transfer?                                                                                | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Other?                                                                                          | Yes              | <input type="checkbox"/> | No                     | <input type="checkbox"/> |             |                          |       |                          |
| Surgeon's notes                                                                                 |                  |                          |                        |                          |             |                          |       |                          |
|                                                                                                 |                  |                          |                        |                          |             |                          |       |                          |
| Intra-operative event                                                                           |                  |                          |                        |                          |             |                          |       |                          |
| Untoward intra-operative event<br>(select all that apply)                                       | None             | <input type="checkbox"/> | Fracture glenoid       | <input type="checkbox"/> | Other       | <input type="checkbox"/> |       |                          |
|                                                                                                 | Fracture humerus | <input type="checkbox"/> | Vascular injury        | <input type="checkbox"/> |             |                          |       |                          |

**Pre-operative Oxford scores – tick one box for every question. If no scores available select pre-operative Oxford scores Not available**

|                                                                                                                                                                                          |                                                  |                                                   |                                                  |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| Pre-operative Oxford score date (DD/MM/YYYY)                                                                                                                                             |                                                  | Not available <input type="checkbox"/>            |                                                  |                                           |
| 1. During the past 4 weeks...<br>How would you describe the <b>worst</b> pain you had <u>from your shoulder</u> ? Not available <input type="checkbox"/>                                 |                                                  |                                                   |                                                  |                                           |
| None <input type="checkbox"/>                                                                                                                                                            | Mild <input type="checkbox"/>                    | Moderate <input type="checkbox"/>                 | Severe <input type="checkbox"/>                  | Unbearable <input type="checkbox"/>       |
| 2. During the past 4 weeks...<br>Have you had any trouble dressing yourself <u>because of your shoulder</u> ? Not available <input type="checkbox"/>                                     |                                                  |                                                   |                                                  |                                           |
| No trouble at all <input type="checkbox"/>                                                                                                                                               | A little bit of trouble <input type="checkbox"/> | Moderate trouble <input type="checkbox"/>         | Extreme difficulty <input type="checkbox"/>      | Impossible to do <input type="checkbox"/> |
| 3. During the past 4 weeks...<br>Have you had any trouble getting in and out of a car or using public transport <u>because of your shoulder</u> ? Not available <input type="checkbox"/> |                                                  |                                                   |                                                  |                                           |
| No trouble at all <input type="checkbox"/>                                                                                                                                               | A little bit of trouble <input type="checkbox"/> | Moderate trouble <input type="checkbox"/>         | Extreme difficulty <input type="checkbox"/>      | Impossible to do <input type="checkbox"/> |
| 4. During the past 4 weeks...<br>Have you been able to use a knife and fork <u>at the same time</u> ? Not available <input type="checkbox"/>                                             |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With extreme difficulty <input type="checkbox"/> | No, impossible <input type="checkbox"/>   |
| 5. During the past 4 weeks...<br>Could you do the household shopping <u>on your own</u> ? Not available <input type="checkbox"/>                                                         |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With extreme difficulty <input type="checkbox"/> | No, impossible <input type="checkbox"/>   |
| 6. During the past 4 weeks...<br>Could you carry a tray containing a plate of food across a room? Not available <input type="checkbox"/>                                                 |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With extreme difficulty <input type="checkbox"/> | No, impossible <input type="checkbox"/>   |
| 7. During the past 4 weeks...<br>Could you brush/comb your hair <u>with the affected arm</u> ? Not available <input type="checkbox"/>                                                    |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With extreme difficulty <input type="checkbox"/> | No, impossible <input type="checkbox"/>   |
| 8. During the past 4 weeks...<br>How would you describe the pain you <u>usually</u> had from your shoulder? Not available <input type="checkbox"/>                                       |                                                  |                                                   |                                                  |                                           |
| None <input type="checkbox"/>                                                                                                                                                            | Very mild <input type="checkbox"/>               | Mild <input type="checkbox"/>                     | Moderate <input type="checkbox"/>                | Severe <input type="checkbox"/>           |
| 9. During the past 4 weeks...<br>Could you hang your clothes up in a wardrobe, <u>using the affected arm</u> ? Not available <input type="checkbox"/>                                    |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With great difficulty <input type="checkbox"/>   | No, impossible <input type="checkbox"/>   |
| 10. During the past 4 weeks...<br>Have you been able to wash and dry yourself under both arms? Not available <input type="checkbox"/>                                                    |                                                  |                                                   |                                                  |                                           |
| Yes, easily <input type="checkbox"/>                                                                                                                                                     | With little difficulty <input type="checkbox"/>  | With moderate difficulty <input type="checkbox"/> | With extreme difficulty <input type="checkbox"/> | No, impossible <input type="checkbox"/>   |
| 11. During the past 4 weeks...<br>How much has <u>pain from your shoulder</u> interfered with your usual work (including housework)? Not available <input type="checkbox"/>              |                                                  |                                                   |                                                  |                                           |
| Not at all <input type="checkbox"/>                                                                                                                                                      | A little bit <input type="checkbox"/>            | Moderately <input type="checkbox"/>               | Greatly <input type="checkbox"/>                 | Totally <input type="checkbox"/>          |
| 12. During the past 4 weeks...<br>Have you been troubled by <u>pain from your shoulder</u> in bed at night? Not available <input type="checkbox"/>                                       |                                                  |                                                   |                                                  |                                           |
| No nights <input type="checkbox"/>                                                                                                                                                       | Only 1 or 2 nights <input type="checkbox"/>      | Some nights <input type="checkbox"/>              | Most nights <input type="checkbox"/>             | Every night <input type="checkbox"/>      |

# Minimum Data Set form – component labels

1. Please affix any component labels to this sheet and ensure any extra component label sheets are attached to the main Minimum Data Set form.
2. Ensure all component details are provided, including cement.
3. The NJR **does not** record the following: wire, mesh, cables or surgical tools.

|                             |                   |
|-----------------------------|-------------------|
| Humeral stem (if used)      | Humeral component |
|                             |                   |
| Glenoid component (if used) | Cement (if used)  |
|                             |                   |
| Accessories                 |                   |
|                             |                   |