

CORRe: Harris Hip Evaluation

Name: _____

Right Hip Left Hip Bilateral

Date / /

Clinic Visit: Pre-Op 6-Week 3-Month 6-Month 1-Year 2-Year 3-Year 5-Year 7-Year 10-Year
 Unscheduled visit:

1. Pain:

	Right	Left
None/Ignores	<input type="checkbox"/>	<input type="checkbox"/>
Slight, occasional	<input type="checkbox"/>	<input type="checkbox"/>
Mild, no effect on ordinary activity	<input type="checkbox"/>	<input type="checkbox"/>
Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Marked, serious limitations	<input type="checkbox"/>	<input type="checkbox"/>
Totally disabled	<input type="checkbox"/>	<input type="checkbox"/>

2. Limp:

	Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>
Slight	<input type="checkbox"/>	<input type="checkbox"/>
Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Severe	<input type="checkbox"/>	<input type="checkbox"/>

3. Support:

	Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>
Cane, long walks	<input type="checkbox"/>	<input type="checkbox"/>
Cane, full time	<input type="checkbox"/>	<input type="checkbox"/>
Crutch	<input type="checkbox"/>	<input type="checkbox"/>
2 canes	<input type="checkbox"/>	<input type="checkbox"/>
Unable to walk/2 crutches	<input type="checkbox"/>	<input type="checkbox"/>

4. Distance:

	Right	Left
Unlimited	<input type="checkbox"/>	<input type="checkbox"/>
6 blocks (1 hr)	<input type="checkbox"/>	<input type="checkbox"/>
2-3 blocks (1/2 hr)	<input type="checkbox"/>	<input type="checkbox"/>
Indoors only (Less than 1 block)	<input type="checkbox"/>	<input type="checkbox"/>
From bed to chair	<input type="checkbox"/>	<input type="checkbox"/>

5. Stairs:

	Right	Left
Normally	<input type="checkbox"/>	<input type="checkbox"/>
Normally with banister	<input type="checkbox"/>	<input type="checkbox"/>
Any method	<input type="checkbox"/>	<input type="checkbox"/>
Not able	<input type="checkbox"/>	<input type="checkbox"/>

6. Shoes/socks:

	Right	Left
With ease	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Unable	<input type="checkbox"/>	<input type="checkbox"/>

7. Sitting:

	Right	Left
Any chair, 1 hr	<input type="checkbox"/>	<input type="checkbox"/>
High chair, 1/2 hr	<input type="checkbox"/>	<input type="checkbox"/>
Unable	<input type="checkbox"/>	<input type="checkbox"/>

8. Transportation:

	Right	Left
Enter public transportation/car	<input type="checkbox"/>	<input type="checkbox"/>
Not able to use public transportation	<input type="checkbox"/>	<input type="checkbox"/>

9. ROM

	Right ROM:	Left ROM:
Flexion	<input type="text"/>	Flexion <input type="text"/>
Flexion Cont.	<input type="checkbox"/> - <input type="text"/>	Flexion Cont. <input type="checkbox"/> - <input type="text"/>
External	<input type="checkbox"/> - <input type="text"/>	External <input type="checkbox"/> - <input type="text"/>
Internal	<input type="checkbox"/> - <input type="text"/>	Internal <input type="checkbox"/> - <input type="text"/>
Abduction	<input type="checkbox"/> - <input type="text"/>	Abduction <input type="checkbox"/> - <input type="text"/>
Adduction	<input type="checkbox"/> - <input type="text"/>	Adduction <input type="checkbox"/> - <input type="text"/>

	Right	Left
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Undocumented, Deformity Exists	<input type="checkbox"/> Undocumented, Deformity Exists	<input type="checkbox"/> Undocumented, Deformity Exists
<input type="checkbox"/> > 10 degrees Fixed Add	<input type="checkbox"/> > 10 degrees Fixed Add	<input type="checkbox"/> > 10 degrees Fixed Add
<input type="checkbox"/> > 10 degrees Fixed Internal Rotation	<input type="checkbox"/> > 10 degrees Fixed Internal Rotation	<input type="checkbox"/> > 10 degrees Fixed Internal Rotation
<input type="checkbox"/> Limb Length Discrepancy > 3cm	<input type="checkbox"/> Limb Length Discrepancy > 3cm	<input type="checkbox"/> Limb Length Discrepancy > 3cm
<input type="checkbox"/> > 30 degrees Fixed Flexion Cont.	<input type="checkbox"/> > 30 degrees Fixed Flexion Cont.	<input type="checkbox"/> > 30 degrees Fixed Flexion Cont.

	Right	Left
Incision length	<input type="text"/> cm	<input type="text"/> cm

10. Leg Length Discrepancy

Left = Right Left < Right Left > Right cm

11. Groin Pain

Right	Left
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Daily	<input type="checkbox"/> Daily
<input type="checkbox"/> Weekly	<input type="checkbox"/> Weekly
<input type="checkbox"/> Monthly	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Charnley Classification

<input type="checkbox"/> A (Unilateral Disease)	<input type="checkbox"/> C1 (Multi-Joint)
<input type="checkbox"/> B1 (Bilateral-Joint Disease)	<input type="checkbox"/> C2 (Systemic Disease- Affecting Mobility)
<input type="checkbox"/> B2 (Bilateral-Arthroplasties)	<input type="checkbox"/> C3 (Both C1 & C2)

CORRe Database: Radiographic Analysis:

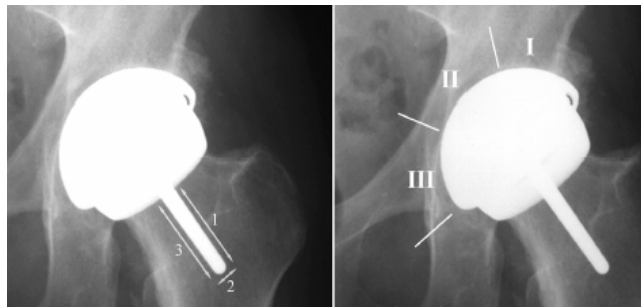
Quality of film Inadequate Film Not Done

<p>Right:</p> <p style="text-align: right;"><input type="checkbox"/> None</p> <p><input type="checkbox"/> Ace. Migration <input type="checkbox"/> Fem. Stress Shield</p> <p><input type="checkbox"/> Ace. Osteolysis <input type="checkbox"/> Neck Narrowing</p> <p><input type="checkbox"/> Ace. Polywear <input type="checkbox"/> Stem Shaft Angle (AP) _____</p> <p><input type="checkbox"/> Ace. Stress Shield <input type="checkbox"/> Stem Shaft Angle (LAT) _____</p> <p><input type="checkbox"/> Femoral Migration <input type="checkbox"/> Cup Abduction _____</p> <p><input type="checkbox"/> Fem. Subsidence <input type="checkbox"/> Cup Anteversion _____</p> <p><input type="checkbox"/> Fem. Osteolysis <input type="checkbox"/> Other: _____</p>	<p>Left:</p> <p style="text-align: right;"><input type="checkbox"/> None</p> <p><input type="checkbox"/> Ace. Migration <input type="checkbox"/> Fem. Stress Shield</p> <p><input type="checkbox"/> Ace. Osteolysis <input type="checkbox"/> Neck Narrowing</p> <p><input type="checkbox"/> Ace. Polywear <input type="checkbox"/> Stem Shaft Angle (AP) _____</p> <p><input type="checkbox"/> Ace. Stress Shield <input type="checkbox"/> Stem Shaft Angle (LAT) _____</p> <p><input type="checkbox"/> Femoral Migration <input type="checkbox"/> Cup Abduction _____</p> <p><input type="checkbox"/> Fem. Subsidence <input type="checkbox"/> Cup Anteversion _____</p> <p><input type="checkbox"/> Fem. Osteolysis <input type="checkbox"/> Other: _____</p>
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Heterotopic Bone: Brooker Classification

- Class 0: No evidence of H/O
- Class 1: Islands of bone within soft tissues.
- Class 2: Bone spurs from femur of pelvis with at least 1cm gap between opposing surfaces.
- Class 3: Bone spurs from prox femur/pelvis <1cm between opposing surfaces.
- Class 4: Ankylosis

Right:	Left:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 0 1 2 3 4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 0 1 2 3 4



Radiolucent lines/Osteolysis:		Right:	Left:
Acetabular:	<input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Femoral:	<input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		<input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Loosening:			
Acetabular:	<input type="checkbox"/> No <input type="checkbox"/> Possible <input type="checkbox"/> Probable <input type="checkbox"/> Definite		<input type="checkbox"/> No <input type="checkbox"/> Possible <input type="checkbox"/> Probable <input type="checkbox"/> Definite
Femoral:	<input type="checkbox"/> No <input type="checkbox"/> Possible <input type="checkbox"/> Probable <input type="checkbox"/> Definite		<input type="checkbox"/> No <input type="checkbox"/> Possible <input type="checkbox"/> Probable <input type="checkbox"/> Definite

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